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Improving Readiness for Nursing Practice via

Simulation in Workplace Violence Mitigation

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Author Note

The data collection for this project took place at the Rural SimCenter, Chico, CA. I have no conflicts of interest to disclose.

Correspondence concerning this project should be address to Paul J Weingartner, School of Nursing, Trinity Hall 107, California State University, Chico, Chico, CA, 95929, United States. Email: pweingartner@csuchico.edu. Free and fair use available upon request.

Table of Contents

Abstract	7
CHAPTER: INTRODUCTION/BACKGROUND	
Workplace Violence	8
Readiness for Nursing Practice	10
Simulation-based Clinical Instruction	13
Use of Simulation for WPV Mitigation Training	14
Practice Gap	15
Theoretical Perspective	16
Kolb's Experiential Learning Theory	16
Experiential Learning Theory and Simulation	19
Conclusion	20
CHAPTER 2: METHODS	22
Design	22
Development of the Simulation Scenarios	22
Participants	
Setting	
Data	
Demographic Survey	
Learners' Perception Survey	
Effectiveness of WPV Curriculum at CSUC School of Nursing Survey	27
Procedures	
Use of the Blackboard Learn (Bb) Course Page	

The Implementation of the Simulation Experience	0
Post-Simulation Survey	5
Analysis	5
CHAPTER 3: RESULTS	7
Descriptive Statistics of Respondent Characteristics	7
Descriptive Statistics of Respondent Attitudes about CSUC WPV Curriculum	7
Descriptive Statistics of Learners' Perceptions: A Pretest-Posttest Comparison 3'	7
Two-Tailed Independent Samples t-Tests of Learners' Perceptions of Knowledge 37	7
Two-Tailed Independent Samples t-Test of Learners' Perceptions of Skills, Ability,	
Confidence, and Preparedness	8
CHAPTER 4: DISCUSSION	4
Limitations	7
Sustainability	7
CHAPTER 5: CONCLUSION)
What Was Learned	9
Implications for Nursing Practice	9
Recommendations for Future Research	0
REFERENCES	1
APPENDIX A: RECOGNIZING CUES FOR VIOLENCE/DE-ESCALATION	
APPENDIX B: DEFENSE OF SELF AND OTHERS DURING CODE SILVER	
APPENDIX C: INFORMED CONSENT FOR PARTICIPATION	
APPENDIX D: DEMOGRAPHIC SURVEY QUESTIONNAIRE	
APPENDIX E: LEARNERS' PERCEPTION SURVEY	

APPENDIX F: EFFECTIVENESS OF WPV CSUC CURRICULUM SURVEY APPENDIX G: WORKPLACE VIOLENCE: WHAT IT IS, WHAT WE CAN DO ABOUT IT

LIST OF TABLES

Table 1: Frequency Table for Nominal Variables of Respondent Characteristics 40
Table 2: Summary Statistics Table for Interval and Ratio Variables of Respondent
Characteristics
Table 3: Frequency Table for Nominal Variables of Respondent Attitudes about CSUC
Curriculum
Table 4: Frequency Table for Ordinal Variables of Learners' Perceptions 42
Table 5: Two-Tailed Independent Samples t-Test for Knowledge by Pretest and
Posttest
Table 6: Two-Tailed Independent Samples t-Test for Skills, Ability, Confidence, and
Preparedness by Pretest and Posttest

LIST OF FIGURES

Figure	1: Kolb's o	experiential	learning theor	v model .	 8
1 1 5 0 1 0			rearining theor	j 1110 a e i i	 ~

Abstract

Workplace Violence (WPV), a significant problem in health care in the United States and worldwide, causes emotional and physical harm to nurses, negatively affects quality care delivery, and contributes to burn out, job dissatisfaction, and attrition. Clinical simulation was used to educate registered nursing students about WPV and train them in mitigation techniques in an effort to improve their awareness and readiness for professional nursing practice. Data from 37 students in their final semester of nursing school were collected anonymously prior to and after reviewing online materials about WPV and attending a 3-hour simulation experience in which two scenarios were presented. Measures of student learners' perceptions of knowledge, skills, ability, confidence, and preparedness to manage aggressive or violent patient behaviors pre- and post-simulation showed statistically significant improvement in all five categories.

Keywords: workplace violence, readiness for practice, clinical simulation

Chapter 1: Introduction/Background

Nursing can be a dangerous profession. Nurses often care for patients with contagious and sometimes deadly diseases; they also use sharp objects and sometimes work in unsafe environments like war zones and natural disaster areas. Probably the most egregious threat to the safety of nurses in clinical spaces is interpersonal violence (most often perpetrated by patients) like verbal/physical aggression and assault, which is one type of workplace violence (WPV) (Occupational Safety and Health Administration [OSHA], 2015). Violent encounters between nurses and patients and persons accompanying patients have been documented since the early 19th century (Ramacciati et al., 2016).

Workplace Violence

WPV is a significant professional problem in health care in the United States, one that has risen to "epidemic levels" (Robert Wood Johnson Foundation, 2015, para. 5). It is also acknowledged as a worldwide problem that is detrimental to the physical and psychological health and safety of nurses and other healthcare providers (American Nurses Association [ANA] Professional Issues Panel on Incivility, Bullying, and Workplace Violence, 2015; International Council of Nurses [ICN], 2017; OSHA, 2015; The Joint Commission, 2018; World Health Organization [WHO], 2002).

The National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC) defines occupational violence as "violent acts, including physical threats of assault, directed toward persons at work or on duty" (CDC, 2018, para 1). The OSHA of the United States Department of Labor adds verbal violence to the NIOSH definition and includes "verbal violence—verbal abuse, hostility, harassment and the likewhich can cause significant psychological trauma and stress" (OSHA, 2015, para 1) in their definition of WPV.

In the United States, healthcare workers and especially nurses (the largest segment of the healthcare workforce) are more likely to be victims of verbal and/or physical assault than are workers in other industries; according to OSHA (2015), between 2002-2013, WPV which required workers to take days away from work for treatment or recovery was four times more prevalent in the healthcare industry than in other industries overall. In 2013, healthcare and social assistance sectors experienced 7.8 incidents of WPV per 10,000 full-time employees compared to two incidents per 10,000 full-time employees in all other industries. Deriving data from the ANA's Health Risk Appraisal survey published in 2014, OSHA also reports that half of all registered nurses and nursing students were verbally abused in 2013 and 21% were physically assaulted (OSHA, 2015).

In addition to the potential for personal physical injury, persistent WPV results in nurses feeling unsafe at work (Burchill, 2015). It also decreases "resilience" and increases "burnout" (Rees et al., 2018) and causes "emotional exhaustion" among nurses (Wolf et al., 2017). Persistent WPV and/or the threat of WPV leads to lost productivity, decreased ability of nurses to provide quality patient care, and attrition of the nursing workforce (Wolf et al., 2014). It also increases absenteeism (Edward et al., 2014) and has significant financial costs to employers (Brous, 2018).

No matter their nursing specialty or location of work, all clinical nurses are at risk for potential violence from patients and others. Threats and acts of violence occur in high acuity units such as emergency and intensive care and also in many other areas of nursing, including medical-surgical, oncology, dialysis, primary care, home health, hospice, and long-term and dementia care (Perkins et al., 2020; Thompson et al, 2019). The overall consequence of WPV is its negative impact on achieving the quadruple aims: improving the patient-centered care experience, improving the health of populations, overall healthcare cost reduction, and improving the care experience for health care providers (Jeffs, 2018).

Readiness for Nursing Practice

Nursing students who are soon to be new nurses must simultaneously accomplish several objectives in order to be ready to practice as professional nurses. To facilitate their progress through professional stages of development from novice to expert (Benner, 1984), they must attain proficient levels of psychomotor skills and display adequate knowledge of evidence-based healthcare delivery. In addition, they must learn how to communicate effectively with non-medical populations (e.g., patients, family members) as well as with other members of the healthcare team (e.g., medical providers, adjunct therapists). They must also develop clinical reasoning skills to anticipate and respond to acute changes in patient conditions. Finally, they must develop ethical comportment (Benner et al., 2010) in order to negotiate sometimes difficult interactions with patients and others in a professional and ethical manner.

Readiness to practice has been defined most broadly as the ability of students to be adequately prepared for safe and independent professional nursing practice upon graduation from nursing school (AlMekkawi & Khalil, 2020; Järvinen et al., 2018). It is a concept that is related but not identical to competence, and one that incorporates one's feelings about and selfperception of being ready (Järvinen et al., 2018). In their literature review, Hickerson et al. (2016) noted the prevalence of a preparation-practice gap in which new nurses are not ready for the intensity of professional nursing practice and subsequently experience increased stress related to the demands of nurse managers and other experienced nurses. They note that changes in nursing education and on-the-job training are necessary for closing the gap. Salem (2021) suggests much of the responsibility for ensuring that nursing students are ready for nursing practice falls on nursing education programs.

Many studies of the factors related to readiness to practice focus less on demonstrable or measured competence and more on students' attitudes and expectations concerning their transition to professional practice. In a scoping review of 17 studies examining factors related to readiness for practice among baccalaureate nursing students in ten countries, Järvinen et al. (2018) identified educational and personal as two main factors, each with subfactors. The educational subfactor of professional competence, described as the sum of knowledge and skills, values and attitudes, was found to be variable among the studies: some students characterized the acquisition of knowledge and skills as adequately preparing them to work as professional nurses, while other studies identified students' lack of confidence in professional readiness and insecurity about working as a nurse. Lack of confidence was related to a second educational subfactor, lack of adequate clinical experience. The authors noted agreement among most studies that students require clinical experience that provides mentoring, feedback, and role-modeling, and is of a sufficient length of time to allow for the accomplishment of learning objectives. Students indicated that more clinical and simulation time would increase their competence (Järvinen et al., 2018). Similar concerns about the mismatch between increased necessary competencies for professional practice and decreased time and clinical sites available for training nursing students was expressed by Salem (2021).

Personal factors related to a students' background also influenced perceptions of readiness to practice. Whereas age made no significant difference among the studies, one study reported male students rated their readiness to practice higher and considered their professional esteem higher than female students (Järvinen et al., 2018). Additionally, some studies suggest employment as a nurse during baccalaureate education had a positive effect on readiness for practice, while another reported that students did not believe readiness for practice would be increased by work experience during education. Similarly, one study found that previous education in healthcare increased students' self-perception of competence, while two others found students who studied other subjects prior to nursing had higher professional esteem than others (Järvinen et al., 2018).

By measuring knowledge of competencies necessary to care for critically-ill patients and perceptions of readiness to practice as critical care nurses among senior students in the last month of their internship year, Salem (2021) found an unsettling disconnect: perceptions of readiness were high while students' knowledge was low. One explanation Salem (2021) offers is that students experience paternalism in clinical education, such that their actions and behaviors are directed and controlled by clinical instructors and host facility staff, whereas the development of nursing knowledge is not. Based upon this finding, Salem recommends embracing teaching methods that promote "critical thinking, clinical reasoning, and knowledge retention such as problem-based and reflective learning" (2021, p. 37). In their narrative review of 12 studies spanning almost two decades, AlMekkawi & Khalil (2020) also found that clinical pedagogies that were problem-based, provided for reflective learning, and incorporated supervision and clinical support were effective in developing students' critical thinking and problem-solving skills.

Despite the lack of widespread agreement on what constitutes readiness for nursing practice, achieving it is easier when nursing students are knowledgeable about safety concerns that exist in the professional environment prior to entry into practice. Preparing nursing students

for the vagaries of clinical practice and training them to respond to potential and actual WPV before it occurs increases their safety which, in turn, allows them to focus on the other objectives of being a new nurse. It is ineffective from a safety perspective and inefficient from a patientcentered care delivery perspective to expect new nurses to develop an awareness of and ability to respond to WPV on the job.

Simulation-based Clinical Instruction

The centrality of traditional clinical instruction to baccalaureate nursing education has been challenged on several fronts; these include lack of understanding of the teaching practices and learning opportunities that contribute to students' learning and skill acquisition; the lack of faculty control over student learning experiences; and questions about the frequency of significant student learning opportunities in clinical settings (Ironside et al., 2014). Nielsen et al. (2013) also suggest that the lack of adequate clinical sites is a significant barrier to clinging to the traditional clinical model of nursing education. Noting a lack of uniformity of state rules and regulations concerning nursing education at the baccalaureate level, Polifroni et al. (1995) questioned who, other than patients, influences clinical nursing students' learning and how much clinical time is actually spent in learning. They discovered that 75% of clinical time is spent by students in unsupervised activities. In their systematic review, Leighton at al. (2021) failed to find a single study that reported a causal link between traditional clinical education models and learning outcomes. They conclude there is insufficient evidence to continue to support such models and express concern about how learning is assessed in traditional clinical courses.

Simulation-based clinical education, on the other hand, is being increasingly recognized as an effective and safe pedagogy in health care (Harder et al., 2013; Lesā et al., 2021; Miles, 2018; Sullivan et al. 2019). Due to increased control over the specifics of the learning

experience, Sullivan et al, (2019) note that simulation partially resolves the randomness of traditional clinical experiences and the subsequent uniqueness of each students' experience while simultaneously allowing students to practice more higher order nursing tasks in less time. In his grounded theory approach to simulation experiences, Miles (2018) noted that simulation allows for transfer of learning within the context of students assuming behavioral roles that are expected of professional nurses. Harder et al. (2013) found that high-fidelity simulation increased student learning while simultaneously decreasing their frustration. Personal attributes that students brought to simulation experiences that influenced their observation, therapeutic response, and reflection on learning were found by Lesā et al. (2021) to be congruent with the process of making clinical judgements.

Use of Simulation for WPV Mitigation Training

The use of simulation pedagogy for WPV education and training has been shown to be effective in increasing nurses' confidence and effectiveness in managing workplace violence. Ming et al. (2019) found that simulation significantly improved nurses' ability to cope with aggression. A review by Johnston and Fox (2020) of studies focusing on WPV education programs for baccalaureate students found that simulation was an effective strategy. Gail et al. (2017) participated in the development of Violence Prevention Exercises (VPE), an education and training program that incorporated simulation-based training, and found that the program increased nurses' sense of confidence and feelings of safety at work. Similarly, Brown et al. (2018) found that training in simulated scenarios of workplace violence increases nurses' abilities to overcome the tendency to freeze and panic when confronted by episodes of violence. Their training approach had two objectives: 1) increase the confidence of health care workers in reacting to violence situations by developing a framework of response, and 2) replace as much as

possible a victim mindset with a survivor's mindset (Brown et al., 2018). The program used simulation to teach participants that it is permissible to break the rules, exert control, and protect themselves as well as other colleagues and patients during situations of violence.

Brown et al. (2018) based their training model on the perceived options health care providers have when confronted by situations of violence. Participants in the training program were encouraged to *accept* that violence was occurring, choose between *barricading* themselves in place or *leaving* the area altogether in order to protect themselves and patients, and if these options were not available, *engage* the perpetrator or otherwise attempt to disrupt the violence. The resultant acronym—ABLE—was a mnemonic that could be easily remembered even in situations of increased stress due to violence. In order to emphasize a more active response to violent situations, the program developers eventually called the program Violence: enABLE Yourself to Respond, otherwise called the enABLE program.

In their study of interprofessional approaches to WPV mitigation and restraint placement in an emergency department (ED), Krull et al. (2019) found that simulation-based education and training significantly improved providers' (nurses, medical providers, security staff, social service workers) knowledge, skills, abilities, confidence, and preparedness to manage workplace violence. Additionally, they found participants with the least professional experience indicated the highest post-simulation satisfaction scores, suggesting that the method was especially effective for those newest to working in the ED.

Practice Gap

Currently, there is no simulation-based education and training in WPV for students in the School of Nursing (SON) at California State University, Chico (CSUC). Nursing students at CSUC graduate at the end of their fifth semester and are eligible to enter the professional workforce shortly thereafter. The SON incorporates simulation-based clinical education in each of the five semesters of the program, and the final semester curriculum is the most appropriate time to provide students with a simulation experience in WPV mitigation.

The purpose of this project was to improve the CSUC School of Nursing's simulationbased education curriculum by providing a heuristic simulation experience in WPV mitigation to improve students' readiness for professional nursing practice upon graduation. Specifically, the project aims to measure the extent to which nursing students in their fifth semester think WPV issues are considered in theoretical, clinical, and simulation courses and whether or not nursing students would benefit from a greater consideration of WPV issues in the curriculum. Additionally, my project aims to measure the effects of online educational materials and a tactile experience of simulated WPV on learners' perceptions of their knowledge, skills, ability, confidence, and preparedness to mitigate workplace violence.

Theoretical Perspective

Kolb's Experiential Learning Theory

The theoretical framework for this project is Kolb's (1984) Experiential Learning Theory. Kolb's theory suggests that learning is enhanced by experience and also by reflection upon the experience, abstract conceptualization about it, and active experimentation in future experiential episodes based upon this reflection and conceptualization. Experiential Learning Theory is amenable to simulation pedagogy because simulation entails experience and reflection upon the experience for the purpose of improving performance in future similar encounters. Several authors note that Kolb's theory is particularly useful in simulation curricular development and understanding the efficacy of simulation-based education for professional nurses and other health professionals as well as nursing students (Bearman & Nestel, 2015; Poore at al., 2014; Stocker et al., 2014; Wong et al., 2015).

Kolb (1984) posited experiential learning theory to challenge the simple notion that undergirds many learning theories: individuals learn primarily through enculturation and didactic teaching methods when being taught by learned instructors or through other educational modalities, like books. Kolb's theory contends that in addition to being taught, learners also learn by doing, in essence, learning from experience. Kolb defines learning as a "process whereby knowledge is created through the transformation of experience" (Kolb, 1984, p. 41).

Kolb (1984) posits that a learning cycle consists of four stages: (a) concrete experience, (b) reflective observation, (c) abstract conceptualization, and (d) active experimentation. In the concrete experience stage the learner is exposed to or participates in an experience. The learner mentally reviews the experience in the reflective observation stage. The abstract conceptualization stage is marked by a consideration and manipulation of thoughts and reflections in order to identify the significance of the experience and what might have been done differently in order to improve the experiential outcome. Finally, in the active experimentation stage, learning achieved in previous stages is applied to future experiences. Kolb (1984) stresses that learners must engage in all four stages for optimal learning to occur; however, depending upon individual learning styles, a learner might have a preference for one stage over the others and therefore not utilize learning from each stage equally.

Kolb (1984) presents four learning styles and associated each with characteristic learner preferences (see also, Manolis et al., 2013). Diverging learners learn best through concrete experience and reflective observation and prefer participating in group work. Assimilating learners prefer abstract concepts and sorting information into concise and logical formats; therefore, assimilating learners learn best in the reflective observation and abstract conceptualization stages. Converging learners are problem solvers and prefer to work on technical tasks. They learn best from abstract conceptualization and experimentation. Accommodating learners prefer hands-on experience and learn best through concrete experience and active experimentation. The relationship between Kolb's stages and Learning styles is depicted in Fig. 1:





Figure 1: Kolb's Experiential Learning Theory (from Manolis et al., 2013, p. 46)

Kolb's (1984) understanding of how knowledge is created through the transformation of experience is based upon two general assumptions. The first is that people adapt and change, and the second is that learning is a recurring cycle. Based upon these assumptions, experiential learning theory posits six propositions.

First, learning is a process. Learning is a series of interconnected events, not a singular event, and using active experience to engage and motivate learners also enriches their learning. Second, all learning is relearning. Learners bring to the experience ideas and beliefs that they

then have an opportunity to integrate with new ideas and beliefs. In this sense, all learning is based upon learning that has preceded it. Third, learning is a dialectic process. Learners utilize various methods of investigating ideas and beliefs from reflecting to acting to feeling and thinking. Fourth, learning is holistic and integrative and takes into account all aspects of a person as they make decisions and/or solve problems. Fifth, interaction between people and the environment results in learning. Learners can understand the possibilities of an experience based upon previous experience. The last proposition is that learning is a process of creating knowledge.

Experiential Learning Theory and Simulation

The cyclic nature of Kolb's theory makes it uniquely conducive to understanding how professional nurses and nursing students learn in simulation-based education. Kolb's concrete experience stage is the simulation scenario in which the learner participates. This is usually a clinically-based scenario depicting a particular nursing event or practice. Rudimentary scenarios might present the learner with an opportunity to perform a task or skill, whereas more complex scenarios might present learners with a patient condition or clinical situation about which the learner must reason from signs and symptoms or patient behaviors to a course of action.

Scenarios may be amenable to either deductive or inductive reasoning. Learners may directly participate in the action of the scenario or vicariously participate by watching the action, either immediately while in the same room, or via closed-circuit television. If the simulation scenario is being presented *in situ*—say, in the department in which a nurse works—immediate observation is more likely; if the scenario is being presented in a simulation center, participant observers often view the action via closed-circuit broadcasting.

Once the experience is complete, learners engage in the stage of reflective observation through individual and/or group debriefing of the scenario. Learners discuss the scenario, in general, and more specifically in terms of what the action they observed during the scenario. They might discuss the clinical reasoning that is expected for a successful outcome and the clinical reasoning and decision making that actually occurred. This process is often facilitated by a confederate of the simulation scenario.

In the abstract conceptualization stage, learners manipulate a variety of concepts integral to the scenario in order to elicit the significance of the experience. Learners might focus on whether or not the scenario was realistic, i.e., similar in content and style to the sort of clinical situation a learner might encounter in a clinical space. Learners often explicate the decisions made and actions taken during the scenario and may envision alternate ways of thinking and decision-making that might change and perhaps improve the outcome of the scenario. Learners might second-guess themselves and question what logic encouraged them to do what they did in the scenario. Learners will often derive more value from an experience of "failure" than one of "success" (Stocker et al., 2014).

Lastly, learning that culminates from the concrete experience, reflective observation, and abstract conceptualization stages can be applied to future scenarios and/or clinical situations. One of the stated purposes of simulation-based education is to improve clinical practice. One of the ways that individual learners can do this is to carry forward into active practice the lessons of the scenario experience via the active experimentation stage.

Conclusion

Kolb's experiential learning theory provides a foundation for understanding how learners transform experience into knowledge. The four stages of the cycle of learning posited by Kolb in connection with his consideration of individual learning styles elucidates how learners are able to carry forward learning from a simulated experience of clinical patient care into future simulations or clinical practice. The theory is well-suited to explain how nurses do what they do and know what they are doing.

Chapter 2: Methods

Design

This pilot study used a quasi-experimental design that incorporated online anonymous demographic and psychometric survey questionnaires, online pre-briefing educational materials, a hands-on experience in simulated verbal and physical aggression, and an evidence-based debriefing of the experience moderated by a trained simulation facilitator. The study is predicated on the clinical experiences of the Principal Investigator (PI) who has worked as a professional ED nurse in various healthcare facilities in the western United States since 2003. It is also an extension of the professional problem-solving paper ("Workplace Violence in the Emergency Department") the PI wrote as a culminating project for his Master of Science in Nursing (MSN) program in 2019. In that paper, the PI advocated using simulation to educate professional ED nurses about WPV and train them in WPV mitigation. The current project advocates using simulation to educate nursing students about WPV and train them in WPV mitigation techniques prior to graduating and becoming professional nurses.

Development of the Simulation Scenarios

Two simulation scenarios were developed by the PI using a scenario template provided by the Rural SimCenter. In the first scenario, entitled "Recognizing Cues for Violence/Deescalation" (See Appendix A), a patient displays the cues of the increasing likelihood of aggression/violence, including staring and eye contact, tone of voice and volume, anxiety, mumbling, and pacing (STAMP) (Luke et al., 2007). The patient is a former US Navy Seal who was honorably discharged from the service after injuring his back. A salient component of the scenario is that the patient is on a "pain contract" with his primary care provider (PCP) at the Veterans Administration (VA). The patient becomes increasingly verbally aggressive, uses abusive and derisive language, and physically threatening, intimidating postures and gestures, as the scenario progresses and depending upon the actions of the student participants.

The learning objectives of the scenario are for student learners to 1) recognize behavioral cues for potential violence, 2) formulate a plan of treatment incorporating patient and staff safety, including maintaining a safe distance from the patient; removing dangerous objects from the environment that can be used as weapons—IV polls on wheels, empty chairs, etc., and especially items carried by nurses (e.g., lanyards, stethoscopes, bandage scissors); positioning oneself between the patient and an exit, and notifying security or other individuals as to the potential for violence, and 3) engage in de-escalation techniques and practice therapeutic communication (Jubb & Baack, 2019; Richmond, 2012).

Prior to the implementation of the simulation experience, the PI identified a former colleague—an emergency department charge nurse the PI worked with at Adventist Health Feather River in Paradise, California—who was willing to participate as the live patient actor. It was also this colleague's mixed ethnic background (Latino and Native American), former military service (US Navy SEAL), and imposing physical characteristics (5'9", approximately 230#, muscular, tattoo sleeves on both arms, etc.) that the PI had in mind when creating the scenario for the WPV curriculum. The PI had numerous conversations with his colleague about the sorts of aggression and violent behavior they had each experienced while working in EDs, and some of these experiences were written into the scenario. Once the scenario was written, the PI met with his colleague on several occasions to review the objectives of the scenario and rehearse its suggested actions and dialogue prior to implementation.

In the second scenario, entitled "Defense of Self and Others during Code Silver" (See Appendix B), a post-operative patient exhibits anxiety and distress and reluctantly reports that his/her distress is related to concern about a relative who has had negative previous interactions with the hospital, has voiced complaints about the nursing and medical staff, and has made threats about "getting even." Details of these comments and threats are shared by the patient. The patient reports the family member's intention to visit and bring a weapon into the facility. At the moment the information is relayed to the student participants, simulated gunshots are heard, and Code Silver (person with a weapon) is paged overhead, indicating a location near the patient's room.

The objectives of the scenario are for student participants to 1) understand/recognize Code Silver (person with a weapon and/or active shooter and/or hostage situation), 2) formulate a plan to run (escape), hide (barricade), or fight (confront) person with weapon, and 3) incorporate patient/medical condition in thinking about options. If the student learners attempt to flee, the patient was scripted to complain that they were not attempting to save him/her. If the student learners would attempt to transfer the patient to a wheelchair, the patient was scripted to complain of excessive pain. The scenario stipulated that multiple pieces of furniture were available in the room as possible items for a barricade, including the patient bed, a bedside table, an over-the-bed patient tray, and a medication dispense cart. The scenario also stipulated that multiple items were also available in the room to be used as potential weapons, including the IV pole, the IV pump, and a fire extinguisher.

This scenario was loosely based on several recent media accounts of patient violence and active shooter situations in US healthcare facilities. The characteristics of the patient, including the patient's name ("Chris"), were intentionally non-binary. This was not necessary to the scenario itself but allowed for selecting a student volunteer among the male and female students in the clinical sections to enact the role of the patient (see below).

Participants

Participants in the project were nursing students enrolled in a fifth semester clinical course entitled NURS424: Practicum in Patient Care Management during the fall semester of 2021. Ineligible for participation were non-nursing majors and nursing majors enrolled in other semesters of the program. Eligible students participated on a voluntary basis and provided informed consent for their participation (See Appendix C). Students were permitted to opt-out at any time without personal or academic penalty. Students who elected not to participate or to opt-out were provided an alternate assignment by their individual clinical instructor in order to satisfy clinical requirements for the California Board of Registered Nursing (BRN). The study was approved by the CSUC Internal Review Board on September 23, 2021.

Setting

The SON at CSUC utilizes the Rural SimCenter of Chico for its simulation-based clinical education. The Rural SimCenter is accredited by the Society for Simulation in Healthcare (SSIH) and, according to its current managing director, is one of the oldest healthcare simulation centers in the world (E. Voelker, personal communication, June 23, 2021). A consortium of local healthcare-related organizations (e.g., Enloe Medical Center, Oroville Hospital, Enloe FlightCare) utilizes its space, equipment, and staff for professional training and baccalaureate nursing education (e.g., CSUC). The Rural SimCenter is located in a former healthcare facility and comprises 3,000 square feet of working space including two classrooms, several simulated hospital rooms, two control centers, and a variety of multipurpose spaces. The center is capable of running two simulations simultaneously, and SimCenter staff provide *in situ* simulation experiences at local healthcare facilities upon request.

The simulation curriculum in the SON is implemented through the program's clinical courses, and the use of simulation pedagogy occurs in each of the five semesters of the program. The nursing program typically enrolls 40 students per cohort in each semester, and each cohort is divided into four 10-student clinical sections with each section having a unique clinical instructor. Whereas students participate in clinical experiences in various host facilities, all students utilize the Rural SimCenter for simulation-based education. Each simulation experiences are prefaced with online educational materials available asynchronously via Blackboard Learn (Bb), the learning management system (LMS) used by CSUC. Online materials traditionally provide basic didactic education about the intended topic of the simulation experience thereby preserving time in the SimCenter to focus on active participation in the simulation scenarios.

Data

A pre-simulation online survey questionnaire developed by the PI was thematically divided into three sections: A Demographic Survey, a Learners' Perception Survey, and an Effectiveness of WPV Curriculum at CSUC School of Nursing Survey. The survey questionnaire was administered to participants via a link to the web-based survey research tool, Qualtrics. *Demographic Survey*

The demographic survey (See Appendix D) was designed to measure the following independent variables: assigned sex at birth; current gender identity; age; estimated current grade point average; work experience during the nursing program; work experience in healthcare during the nursing program; volunteer experience during the nursing program; volunteer experience in healthcare during the nursing program; estimated hours of academic study per week during program semesters (i.e., not during academic breaks); estimated hours of paid employment per week during program semesters; and estimated hours of volunteer work per week during program semesters; previous experience with WPV, either as a witness to or as a recipient of violence. Several open-ended questions provided the opportunity for respondents to elaborate on their work experience, their volunteer experience, and any details of their experience(s) of WPV they wished to share.

Learners' Perception Survey

A Learners' Perception Survey (See Appendix E) consisted of a 5-item attitudinal questionnaire adapted with permission from Krull et al. (2019). The questionnaire was administered as a component of the pre-simulation online survey questionnaire as well as separately as a post-simulation survey. The questionnaire was designed to measure the variables of students' level of agreement to statements concerning perceptions of their knowledge, skills, ability, confidence, and preparedness to mitigate WPV based upon a Likert scale with 5-responses: Strongly Agree (SA), Agree (A), Undecided (U), Disagree (D), Strongly Disagree (SD). Krull et al. (2019) report that Cronbach's α showed high reliability of the tool. The tool administered in their pretest resulted in an $\alpha = 0.9648$ and in their posttest $\alpha = 0.9737$. Content validity of the original tool was established by input from project stakeholders.

Effectiveness of WPV Curriculum at CSUC School of Nursing Survey

An Effectiveness of WPV Curriculum at CSUC School of Nursing Survey (See Appendix F) was administered as a component of the pre-simulation online survey questionnaire. It was designed to measure the variables of students' level of agreement with statements about the effectiveness of the CSUC nursing program's education on WPV in three content areas of the curriculum: theoretical/classroom, clinical, and simulation, respectively. Similarly, the questionnaire was designed to measure the variables of students' level of agreement with statements about whether more WPV content in the three content areas would be beneficial to students. Responses were based upon a Likert scale with 5-responses: Strongly Agree (SA), Agree (A), Undecided (U), Disagree (D), Strongly Disagree (SD).

Procedures

The WPV mitigation simulation curriculum was designed to be a permanent curricular component of NURS424: Practicum in Patient Care Management, a clinical course that did not utilize clinical simulation. Tentative interest in the addition of a simulation experience in NURS424 was garnered through a presentation by the PI to the fifth semester nursing faculty committee during Spring 2021. The committee included several NURS424 instructors as well as student representatives from the fifth-semester cohort in Spring 2021. Both faculty and students expressed enthusiastic interest in the project. Subsequently, the NURS424 faculty agreed to implement the simulation experience in NURS424 during Fall 2021 and to provide faculty for facilitation of the simulation portion of the curriculum in future semesters after the initial project was completed. The PI agreed to provide all support materials and facilitate the simulation experience for all fifth-semester clinical students during the initial implementation of the project in Fall 2021.

Use of the Blackboard Learn (Bb) Course Page

One month prior to the in-person simulation experience, identical Improving Readiness for Professional Nursing Practice content modules were created and posted to the Bb course page for each of the four clinical sections of NURS424. The content module consisted of four sections: Informed Consent for Participation; Qualtrics Survey Link; Improving Readiness for Professional Nursing Practice curriculum; and Qualtrics Post Simulation Survey. The Bb "adaptive release" function allowed the PI to limit participant access to sections of the content module based upon their acknowledgment of a willingness to continue participating (described below).

The Informed Consent for Participation section of the content module permitted eligible student participants to access the Informed Consent document and included the following explanation/instructions: "The attached document explains the current project. Please read the document carefully. Please follow the directions at the end of the document to indicate that you either agree to participate or decline to participate. Clicking on the Mark Reviewed button below is implicit acknowledgment that you voluntarily agree to participate."

Eligible students who voluntarily elected to participate were subsequently permitted access to the pre-simulation survey questionnaire via the Qualtrics Survey Link section of the content module which included the following explanation/instructions: "Please click on the Qualtrics Survey Link to access the survey questionnaire. Completing the survey is expected to take no more than 10-15 minutes, depending upon how much of your past experience you choose to share. Please access the survey only once and complete it in a single sitting. After you have completed the Qualtrics Survey, please click on the Mark Reviewed button below. You will be given access to a Content Module that includes the study materials for the simulation experience. Note: Submitting the survey and clicking the Mark Reviewed button is implicit acknowledgement that you voluntarily agree to continue participating in this project."

The pre-simulation survey questionnaire was available to students via a Qualtrics link from November 15, 2021, at 0001 until December 3, 2021, at 0700. As is noted, students were implored to complete and submit the survey only once. All survey responses were submitted anonymously and have been subsequently kept strictly confidential by the principal investigator. Of 39 students enrolled in the course, 37 accessed and submitted the pre-simulation survey questionnaire and subsequently clicked on Mark Reviewed. (One survey questionnaire was accessed and submitted but left blank. Whether this was intentional or represents user error is undetectable.)

When student participants clicked Mark Reviewed in the Qualtrics Survey Link section of the content module, they were permitted access to the Improving Readiness for Professional Nursing Practice curriculum section of the content module which included pre-briefing education materials and clinical practice tools on WPV. This curriculum included the following items: 1) an article entitled "Nurse-Directed Violence in the Workplace" (Hertel, 2019), described as a primer on WPV; 2) an article on cue recognition of patient behaviors that are associated with potential violence entitled "STAMP: Components of Observable Behaviour that Indicate Potential for Patient Violence in Emergency Departments" (Luck et al. 2007); 3) two articles on de-escalation strategies and techniques: "Verbal De-escalation for Clinical Practice Safety" (Jubb & Baack, 2019) and "Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup (Richmond et al., 2012); 4) a PowerPoint presentation created by the PI entitled "Workplace Violence: What It Is, What We Can Do About It" (See Appendix G); 5) a document entitled "Joint Commission Standards on Restraint and Seclusion" (Crisis Prevention Institute, 2009); 6) a link to an online video "RUN. HIDE. FIGHT.® Surviving an Active Shooter Event" available on YouTube; 7) a list of standardized hospital emergency codes; and 8) information on the Simulation Schedule for the various clinical sections. This section of the content module was open to students throughout the remainder of the semester.

The Implementation of the Simulation Experience

Each clinical section of NURS424 participated in a 3-hour simulation experience conducted either in the morning, 0900-1200, or afternoon, 1300-1600, on Friday, December 3, 2021, and Tuesday, December 7, 2021. Students in the earlier simulation sessions were instructed not to share the content of the simulation scenarios with their student colleagues in later sections so as not to negatively impact future participants' learning. Of 39 students enrolled in NURS424, 37 participated in the simulation experience. On Friday, December 3, there were ten students in the first session and nine in the second session; on Tuesday, December 7, there were nine students in the first session and ten in the second. Because the seven male students in the cohort are evenly divided among the four clinical sections (2, 2, 2 and 1, respectively), each simulation class contained at least one male student.

The simulation classes utilized Classroom O and Room 602 of the SimCenter. All classroom activities including introduction, pre-briefing, and debriefing occurred in the classroom. Participant observers remained in the classroom during simulation scenarios and viewed the scenarios on a video monitor via Zoom.

The simulation scenarios created by the PI were presented during the simulation experience for each clinical section. The simulation sessions were structured to provide similarity of experience among clinical sections. Each session began with an introduction and logistical information about the SimCenter—use of the bathrooms, issues of confidentiality, use of pencils only, etc. A brief overview of the subject matter of the simulation scenarios was then provided, and students were reminded of the opportunity to opt out at any time for any reason and that mental health services could be secured at the WellCat Counseling Center or via the center's crisis line at any time. As mentioned above, nursing students at CSUC completed simulations in previous clinical courses, so neither the SimCenter regulations nor the purpose of simulation as a pedagogy were unfamiliar to them.

Prior to the first scenario, volunteers were solicited from among the students to play the professional nurse role in the scenario. The PI was committed to allowing the first two students who volunteered to participate in the scenario, and it happened that in each clinical section, the first two volunteers were a female student and a male student. Also prior to the scenario, the purpose of a PCP pain contract was explained to students. It was apparent to the PI that pain contracts are not a healthcare item with which students are familiar. This is most likely the result of pain contracts being primarily encountered in emergency nursing and perhaps in outpatient nursing and there are no specific courses in the CSUC nursing curriculum that specifically focusing on these areas of nursing. The two volunteer participants were then removed from the classroom and shown a copy of the patient's pain contract before the scenario began. The scenario commenced when the students entered Room 602.

During the enactment of the scenario, the live actor playing the role of the patient (the PI's colleague) relied on some personal experiences of aggression/violence that he encountered as an ED nurse to realistically portray increasing agitation and threatening violence. These experiences included the batting of a urinal across the patient room, the twirling of a bedsheet into a "rope," the fashioning of this rope into a noose, and the menacing handling of the noose as if to use it to attempt to strangle someone. In fact, the PI and live actor have a mutual friend, also an ED nurse, who was strangled by a patient in this very manner; fortunately, she was rescued before any dire physical harm occurred.

When the objectives of the first scenario were met or it became clear to the facilitator that additional time to meet outstanding objectives would not be productive, the scenario was ended,

and the students returned to the classroom along with the live actor patient. Debriefing began with an introduction of the live actor to the class and an expression of gratitude for his willingness to participate. The debriefing focused on cue recognition for aggressive behavior and the reasonable steps nurses can take to alleviate patient suffering while maintaining safety, including therapeutic communication and de-escalation techniques. The live actor participated in the debriefing session and shared with the students some examples of his experiences of aggression/violence perpetrated by patients, including those experiences that factored into his acting in the scenario. This provided an increased measure of realism for the students. Debriefing took approximately 30 minutes. Students were then permitted a break.

After reconvening, the second scenario was briefly introduced, and again, volunteers for participation in the role of the professional nurse were solicited from among the students. An aspect of the implementation of the second scenario unique to the WPV mitigation simulation curriculum was the use of a student volunteer to be the scripted live actor playing the role of the patient. In previous clinical simulation experiences in earlier semesters, CSUC nursing students often play the role of professional nurses or the role of a family member or friend in the scenarios but the patient is typically a high-fidelity manikin. The use of a student live actor provides realism to the second scenario and avoids the likelihood that student participants playing the role of professional nurses might become injured by lifting or moving the high-fidelity manikin in the context of the scenario.

Similar to the fortunate circumstance of both a female student and male student volunteering to participate in the first scenario in each clinical section, it was fortunate that in two clinical sections a female student volunteered to be the live actor in the second scenario and that a male student volunteered to play the role in the other two clinical sections. As mentioned above, the scenario was intentionally written with a non-binary patient in mind.

Following the best practice standards for simulation design of the International Nursing Association for Clinical Simulation and Learning (INACSL) and the best practice standards of the Association of Standardized Patient Educators (ASPE) for those working with human actors, every effort was made to inform potential student volunteers of the dramatic and emotional nature of the scenario and suggest that previous significant experience with workplace violence or an active shooter situation might be a contraindication for participation. In one of the clinical sections, in fact, a student did relate that they had had a gun pointed at them by an assailant in the past and so they declined to volunteer to participate.

Prior to the second scenario as well, the video "RUN. HIDE. FIGHT.® Surviving an Active Shooter Event" was shown as a pre-briefing tool. Additionally, the participant volunteers were permitted access to the patient's "chart" (See Appendix F).

When the second scenario was completed, an approximately 30-minute debriefing included the student live actor who played the role of the patient. Debriefing focused on recognizing healthcare facility emergency codes and the deliberation process nurses might use to decide whether to run, hide or fight. Debriefing also considered the many objects, large and small, in a hospital room that might be used as potential weapons or for the purpose of barricading the door. It was also noted that whereas hospital room doors do not lock, bathroom doors in hospital rooms do, and so a bathroom might be a suitable place to hide. It was also related to the students by the PI that no local, state, or federal law requires nurses to provide for the safety of their patients in a Code Silver situation, and that no nationally-recognized nurses association or other nursing organization recommends the nurses put the safety of their patients above their own safety.

Post-Simulation Survey

As indicated above, the Learners' Perception Survey was administered as a postsimulation survey as well. It was available to students after all four clinical sections of the course had completed the simulation experience via the Improving Readiness for Professional Nursing Practice content module on the Bb course page. It was available from December 3, 2021 at 1600 until December 10, 2021 at 1600. Of the 39 students enrolled in the course, 33 students accessed the survey and submitted their responses via Qualtrics.

Analysis

Intellectus Statistics was engaged for data management and analyses. Deidentified survey data were exported from Qualtrics and downloaded to the PI's computer as an Excel file in January 2022 and then uploaded to the Projects menu of Intellectus Statistics. The PI did most of the data cleaning and editing prior to having several consulting sessions with various Intellectus Statistics consultants in February and March of 2022.

Data analysis consisted of the tabulation of descriptive statistics indicating the general characteristics of the participants in the simulation experience as well as participants' attitudes about the nursing program's education about WPV issues. Because the objective of this project is to improve nursing students' readiness for nursing practice through education on WPV and training to responding to and mitigate episodes of WPV vis simulation, a summary measure of whether exposure to the simulation experience improved learners' perceptions of their knowledge, skills, ability, confidence, and preparedness to mitigate WPV was also produced. A non-paired *t*-test statistic was calculated for the pre- and post-simulation Learners' Perception
surveys (identified as Pretest and Posttest) to determine whether changes in students' perceptions of knowledge, skills, ability, confidence, and preparedness to mitigate WPV were statistically significant.

Chapter 3: Results

Descriptive Statistics of Respondent Characteristics

Most participants were female (n = 29, 80.56%) and employed (n = 29, 80.56%) at the time of the study. Of those employed, most were employed in health care (n = 16, 51.61%). Most participants also report having volunteer experience during the nursing program (n = 24, 66.67%) with most volunteer experiences occurring in healthcare settings (n = 19, 63.33%). Most participants denied previous exposure to WPV (n = 20, 55.56%). Frequencies and percentages are presented in Table 1.

The average age of participants was 26 years. The average estimated GPA was 3.78. The summary statistics can be found in Table 2.

Descriptive Statistics of Respondent Attitudes about CSUC WPV Curriculum

Most participants disagreed that WPV is effectively presented in CSUC's theory curriculum (n = 19, 52.77%), the clinical curriculum (n = 23, 63.88%), and the simulation curriculum (n = 23, 63.88%). Most participants agreed that it would be beneficial to have more WPV content in CSCU's theory curriculum (n = 34, 94.44%), the clinical curriculum (n = 33, 91.66%), and the simulation curriculum (n = 34, 94.44%). Frequencies and percentages are presented in Table 3.

Descriptive Statistics of Learners' Perceptions: A Pretest-Posttest Comparison

Frequencies and percentages were calculated for Learners' Perceptions of Knowledge, Skills, Ability, Confidence, and Preparedness to mitigate WPV by the Pretest and Posttest. The results are presented in Table 4.

Two-Tailed Independent Samples t-Test of Learners' Perception of Knowledge

A two-tailed independent samples *t*-test was conducted to examine whether the mean of Knowledge was significantly different between the Pretest and Posttest. For Knowledge, the assumption of normality, measured by the Shapiro-Wilk test (Razali & Wah, 2011), was violated, and the assumption of homogeneity of variance, measured by Levene's test, was met. Therefore, a Student's t-test was conducted.

The result of the two-tailed independent samples *t*-test for Knowledge was significant based on an alpha value of .05, t(67) = -6.51, p < .001, indicating the null hypothesis can be rejected. This finding suggests the mean of Knowledge was significantly different between the Pretest and Posttest. The results are presented in Table 5.

Two-Tailed Independent Samples t-Test of Learners' Perceptions of Skills, Ability,

Confidence, and Preparedness

Two-tailed independent samples *t*-test were conducted to examine whether the mean of Skills, Ability, Confidence, and Preparedness were significantly different between the Pretest and Posttest. For each of the variables, the assumption of normality, measured by the Shapiro-Wilk test (Razali & Wah, 2011), was violated, and the assumption of homogeneity of variance, measured by Levene's test, was also violated. For this reason, Welch's t-test was used instead of Student's t-test, which is more reliable when the two samples have unequal variances and unequal sample sizes (Ruxton, 2006).

For Skills, the result of the two-tailed independent samples *t*-test was significant based on an alpha value of .05, t(51.42) = -7.90, p < .001, indicating the null hypothesis can be rejected. This finding suggests the mean of Skills was significantly different between the Pretest and Posttest. The result of the two-tailed independent samples *t*-test for Ability was significant based on an alpha value of .05, t(63.17) = -5.96, p < .001, indicating the null hypothesis can be rejected. This finding suggests the mean of Ability was significantly different between the Pretest and Posttest.

The result of the two-tailed independent samples *t*-test for Confidence was significant based on an alpha value of .05, t(58.04) = -7.20, p < .001, indicating the null hypothesis can be rejected. This finding suggests the mean of Confidence was significantly different between the Pretest and Posttest.

The result of the two-tailed independent samples *t*-test for Preparedness was significant based on an alpha value of .05, t(64.36) = -7.08, p < .001, indicating the null hypothesis can be rejected. This finding suggests the mean of Preparedness was significantly different between the Pretest and Posttest. The results are presented in Table 6.

Variable	n	%
Gender		
Female	29	80.56
Male	7	19.44
Employment during nursing program		
Yes	29	80.56
No	7	19.44
Employment in health care		
Yes	16	51.61
No	15	48.38
Volunteer experience during nursing program		
Yes	24	66.67
No	12	33.33
Volunteer experience in health care		
Yes	19	63.33
No	11	36.66
Experience of WPV		
No	20	55.56
Yes	16	44.44
Note Due to nounding among nonconteness may not actual 1000/		

Frequency Table for Nominal Variables of Respondent Characteristics

Note. Due to rounding errors, percentages may not equal 100%.

Table 2

Summary Statistics Table for Interval and Ratio Variables of Respondent Characteristics

Variable	М	Standard Deviation	n	Minimum	Maximum
Age	26.11	7.88	36	21.00	53.00
Estimated GPA	3.78	0.19	36	3.00	3.99

Frequency Table for Nominal Variables of Respondent Attitudes about CSUC Curriculum

Variable	n	%
Effective WPV content in theory curriculum		
Agree	9	25
Undecided	8	22.22
Disagree	19	52.77
Effective WPV content in clinical curriculum		
Agree	7	19.44
Undecided	6	16.67
Disagree	23	63.88
Effective WPV content in simulation curriculum		
Agree	2	5.55
Undecided	10	27.78
Disagree	23	63.88
Missing	1	2.78
Benefit of more WPV content in theory curriculum		
Agree	34	94.44
Undecided	1	2.78
Disagree	1	2.78
Benefit of more WPV content in clinical curriculum		
Agree	33	91.66
Undecided	3	8.33
Benefit of more WPV content in simulation curriculum		
Agree	34	94.44
Undecided	1	2.77
Disagree	1	2.77

	Test		
Variable	Pretest $(n = 36)$	Posttest ($n = 32$)	
Knowledge			
Disagree	8 (22.22%)	0 (0.00%)	
Undecided	9 (25.00%)	0 (0.00%)	
Agree	19 (52.77%)	32 (56.25%)	
Skills			
Disagree	10 (27.78%)	0 (0.00%)	
Undecided	16 (44.44%)	0 (0.00%)	
Agree	10 (27.78%)	32 (100.00%)	
Ability			
Disagree	6 (16.66%)	1 (3.12%)	
Undecided	16 (44.44%)	0 (0.00%)	
Agree	14 (38.89%)	31 (96.88%)	
Confidence			
Disagree	12 (33.33%)	0 (0.00%)	
Undecided	15 (41.67%)	3 (9.38%)	
Agree	9 (25.00%)	29 (90.62%)	
Preparedness			
Disagree	11 (30.55%)	1 (3.12%)	
Undecided	16 (44.44%)	1 (3.12%)	
Agree	9 (25.00%)	30 (93.75%)	

Frequency Table for Ordinal Variables of Learners' Perceptions

Note. Due to rounding error, percentages may not sum to 100%.

	Pre	test	Pos	ttest			
Variable	М	SD	М	SD	t	р	d
Knowledge	3.33	0.86	4.45	0.51	-6.51	< .001	1.59

Two-Tailed Independent Samples t-Test for Knowledge by Pretest and Posttest

Note. N = 69. Degrees of Freedom for the *t*-statistic = 67. *d* represents Cohen's *d*.

Table 6

Two-Tailed Independent Samples t-Test for Skills, Ability, Confidence, and Preparedness by Pretest and Posttest

	Pre	etest	Post	ttest			
Variable	М	SD	М	SD	t	р	d
Skills*	2.94	0.86	4.21	0.42	-7.90	<.001	1.88
Ability**	3.17	0.85	4.21	0.60	-5.96	<.001	1.43
Confidence***	2.83	0.91	4.12	0.55	-7.20	<.001	1.72
Preparedness****	2.92	0.81	4.12	0.60	-7.08	<.001	1.70

*N = 69. Degrees of Freedom for the *t*-statistic = 51.42. *d* represents Cohen's *d*.

**N = 69. Degrees of Freedom for the *t*-statistic = 63.17. *d* represents Cohen's *d*.

*** N = 69. Degrees of Freedom for the *t*-statistic = 58.04. *d* represents Cohen's *d*.

**** N = 69. Degrees of Freedom for the *t*-statistic = 64.36. *d* represents Cohen's *d*.

Chapter 4: Discussion

This pilot study aimed to measure the effects of online educational materials and a tactile experience of simulated WPV on learners' perceptions of their knowledge, skills, ability, confidence, and preparedness to manage aggressive or violent patient behaviors. Additionally, this pilot study aimed to measure the extent to which nursing students in their fifth and final semester in the CSUC nursing program believe WPV issues are considered in theoretical, clinical, and simulation courses and whether or not nursing students would benefit from a greater consideration of WPV issues in the curriculum.

The outcomes of the study indicate that using simulation pedagogy to educate nursing students about WPV and train them in mitigation strategies is effective. Pre- and posttest survey analysis demonstrates statistically significant improvement in students' self-perceptions of knowledge of WPV as well as a statistically significant improvement in their perceived skills, abilities, and confidence to manage aggressive or violent patient behaviors and their being prepared to do so. Krull et al. (2019) found similar improvements in all categories using the same pretest-posttest survey tool with an interprofessional sample of healthcare employees in an emergency setting who experienced simulated patient aggression and the need for restraint application. Brown et al. (2018) also found that professional healthcare employees indicated improved preparedness to deal with violent situations after participating in the enABLE training program which included a simulated Code Silver event. Although no statistical data is reported, Gail et al. (2017) found that participant feedback indicated the value of their site-specific violence prevention experiences (VPEs).

Whereas the greatest significant improvement among professionals in the Krull et al. (2019) study was in preparedness to manage aggressive or violent patient behavior, the measures of knowledge and skills needed to manage aggressive or violent patient behaviors showed the greatest improvement among my sample of nursing students. Whereas in pretest 17 students either disagreed or were undecided about having the knowledge needed to manage aggressive or violent patient behaviors and 19 students agree they did have the needed knowledge, none of the students disagreed or were undecided about their knowledge in the posttest, and all of the students (n = 32) reported agreeing that they did have the needed knowledge. Similarly, whereas in the pretest 26 students either disagreed or were undecided about their students agree they did have the needed knowledge is skills needed to manage aggressive or violent patient behaviors and 10 students agree they did have the needed skills needed to manage aggressive or violent patient behaviors and 10 students agree they did have the needed skills in the posttest, and all students (n = 32) reported agreeing that they did have the needed skills. Because simulation is a method that allows students to apply their knowledge and practice skills in a simulated patient care environment, it is significant that these two areas saw the greatest improvement after the implementation of the intervention.

Similar but somewhat less dramatic results were found in the categories of ability, confidence, and preparedness to manage aggressive or violent patient behavior. Of 36 students in the pretest, 22 either disagreed or were undecided about having the ability to manage aggressive or violent patient behavior whereas only one student disagreed in the posttest, while students who agreed they had the ability increased from 14 to 31. Whereas 12 students disagreed they had the confidence to manage aggressive or violent patient behavior and 15 were undecided in pretest, only three were undecided and zero disagreed in the posttest. In the same category, only nine students agreed they had the confidence to manage aggressive or violent patient behavior in pretest, whereas the number increased to 29 in the posttest. Lastly, in the category of preparedness, 27 students in pretest either disagreed or were undecided about being preparedness to manage

aggressive or violent behavior, whereas only two students were undecided or disagreed in posttest. Nine students who agreed to being prepared in pretest increased to 30 students in posttest. Because this project hopes to improve students' readiness for professional nursing practice, improvement in perceived ability, confidence, and preparedness to manage the ubiquitous issue of WPV in healthcare was significant.

Students expressed overwhelming disagreement with statements pertaining to the effective presentation of WPV in the theory, clinical, and simulation curricula at CSUC. Nineteen students disagreed that WPV was effectively presented in theory courses compared to nine students agreeing that it was and eight students remaining undecided. Twenty-three students disagreed that WPV was effectively presented in clinical and simulation courses, respectively, compared to seven students agreeing and six remaining undecided about clinical courses and two students agreeing and ten remaining undecided about simulation courses. Whether the ineffectiveness of the presentation of WPV in the curriculum is related to the amount or kind of content was not measured. However, that so many students disagree that WPV is effectively presented in each of the three areas of the curriculum suggests that students are unprepared for the reality of workplace violence upon graduation.

This fact is demonstrated in student attitudes on the potential benefits of greater amounts of WPV content in theory, clinical, and simulation courses. Thirty-four students agreed that more WPV content would be beneficial in theory courses, 33 students agreed that it would be beneficial in clinical courses, and 34 students agreed it would be beneficial in simulation courses. Clearly, increasing the amount of content related to WPV throughout the curriculum was seen by students to be beneficial. That their self-perceptions of knowledge, skills, ability, confidence, and preparedness show statistically significant improvement after implementation of simulation curriculum in WPV mitigation helps to explain why they believe more WPV content would be beneficial.

Limitations

Although improvement in self-perceptions of knowledge, skills, ability, confidence, and preparedness after the implementation of a simulation curriculum in WPV is note-worthy, this study does not measure the effectiveness of the application of these factors in actual patient care scenarios either collectively or by individual student. This study also does not measure the extent to which knowledge, skills, ability, confidence, and preparedness are retained over time.

Furthermore, no attempt was made to correlate demographic characteristics of the student respondents with improvements in knowledge, skills, ability, confidence, and preparedness. Whereas some literature attempts to understand the effects of characteristics such as gender, age, estimated GPA, and work experience during nursing training on perceptions of readiness (Järvinen et al., 2018), the use of an anonymous survey in this pilot study prevented making any such inferences. As well, although the survey response rates were very good (92.3% and 82.0%, respectively), the total number of students participating in the simulation experience was small relative to the number of baccalaureate nursing students nearing graduation in the United States at any one time.

Sustainability

As previously stated, the WPV simulation experience was conceived to be a permanent part of the fifth semester curriculum in the CSUC School of Nursing, and initial discussions with the fifth semester faculty focused on how this could be accomplished. The PI offered the Bb course materials and the simulation scenarios to the NURS424 faculty with the understanding that the clinical instructors in the course would implement the experience in future semesters. It was disappointing, therefore, to be informed by the lead instructor for NURS424 that the experience would not be made a permanent part of the NURS424 course plan. Citing the expense of using the simulation center and the fact that the structure of the debriefings was a hybrid of traditional simulation debriefing and lecture, the lead instructor informed the PI that in future semesters the faculty would present a lecture and video on WPV to students during the orientation to the course.

Chapter 5: Conclusion

What Was Learned

It was learned in this study that a simulation experience that includes online pre-briefing materials about WPV, a hands-on experience of simulated patient aggression and violence, and a collective debriefing of the experience improves nursing students' perceptions of knowledge, skills, ability, confidence, and preparedness to manage aggressive or violent patient behaviors. It was also learned that students overwhelmingly believe that the CSUC School of Nursing curriculum does not effectively present WPV content in theory, clinical, and simulation courses, and that students believe it would be beneficial for more WPV content to be presented in these courses. This provides valuable data for improving the quality of the CSUC simulation curriculum in nursing.

Implications for Nursing Practice

The national average turnover rate for nurses is 19.1%, with 18% of new nurses leaving their current employment and/or the profession in the first year after graduation and another one-third leaving within two years (Lockhart, 2020). Prior to the COVID-19 pandemic, WPV was implicated in attrition rates for professional nurses (Brous, 2018; Rees et al., 2018; Wolf et al., 2014). Whereas factors affecting attrition have changed, workplace safety is frequently cited as a concern of nurses who consider leaving their current position or are likely to leave. A recent McKinsey & Company report (Berlin et al., 2022) indicates the number one factor influencing nurses' decisions whether to stay in a current position was safety in the work environment. Similarly, for nurses who were "likely to leave" their current position, safety was the number one factor affecting their decision. Therefore, preparing nursing students to know what to expect

when they enter the workforce and know how to mitigate untoward circumstances can potentially reduce the new nurse attrition rate.

Recommendations for Future Research

Clinical simulation education is more often used as a method to practice the application of knowledge and performance of skills rather than evaluating participants' knowledge or performance. Measurement of knowledge and/or the performance of skills to manage aggressive or violent behaviors in simulation scenarios, however, could be beneficial. A formative assessment tool could be created based upon the literature for recognizing cues for violence, applying de-escalation strategies, and responding to Code Silver, and used to evaluate participant performance for the purpose of improving future performance.

Assessing the retention of knowledge and skills learned and applied in simulation and comparing rates with traditional clinical education might also be beneficial to demonstrate simulation's impact on learning. Similarly, implementing the WPV simulation curriculum at more than one time in the five semesters of the CSUC nursing program might be beneficial to determine if the accumulation of general nursing knowledge is associated with improvements in knowledge and skills. Future studies could also focus on the retention of knowledge and skills over time and whether the simulation experience had any impact on how new nurses managed WPV in practice. Attrition rates among new nurses who had experienced a WPV simulation versus those who had not could also be explored.

Because the Rural SimCenter is capable of conducting *in situ* programs at remote health care facilities, using the WPV simulation curriculum for professional nurse continuing education might be beneficial for health care facilities that do not have sufficient financial resources to provide WPV education and training to staff.

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Pt. Name Enrique Fuentes

Appendix A

Scenario Name: Recognizing Cues for Violence/De-escalation	earner Preparation Exercise:
High Fidelity Low Fidelity Volunteer Actor Target Group: Student Professional Level: Advanced Intermediate Beginner Learning Objectives: 1. Recognize behavioral cues for potential violence 2. Formulate plan of TX incorporating patient and staff safety 3. Engage in de-escalation techniques 4. Practice therapeutic communication Secondary Objectives: 1. 1. Correctly identify patient 2. Recognize potential Post-Traumatic Stress Disorder 3. Unclutter triage/treatment room environment 4. Notify colleague of location 5. Verify pain contract 6. Practice refusing client requests for pain medicine 7. Call Code Gray – Combative person	 eview: (Insert skills or readings students should review) Correct patient identification (2 patient identifiers) Patient safety Safety of all staff Recognize cues for potential violence Create a plan of care that incorporates patient and staff safety Implement de-escalation techniques to defuse aggressive situation Luck, L., Jackson, D., & Usher, K. (2007). STAMP: components of observable behavior that indicate potential for patient violence in emergency departments. <i>Journal of Advanced Nursing</i>, 59(1), 11–19 Richmond, J.S., Berlin, J.S., Fishkind, A.B., Holloman, G.H., Zeller, S.L., Wilson, M.P., Rifai, M.A., & Ng, A.T. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. <i>Western Journal of Emergency Medicine</i>, 13(1), 17–25. sert Scenario Summary (Basic overview of Case) ong male patient presents with generalized pain. States he on a Pain Contract through his VA PCP. Displays S/S of increased agitation. quests pain medication beyond contract parameters. Becomes increasingly rbally assaultive and physically threatening.



Initial Subjective Data:	Patient I	nformation	
Background Information: Patient is former US Navy SEAL honorably discharged the	Name	Enrique Fuentes	
previous year for L4 and L5 vertebral disc herniation and persistent		28	
RLE pain. Pt has pain contract with VA PCP due to addiction to	Age.	20	
PO narcotics. Pt receives RX refill for oxycodone 10/325mg every	Birthdate	: 06/16/XXXX	1 al
medication.	Gender:	Cisgender	
	Weight:	5'10"	
Past History:	Height:	235 (106.8 kg)	Enrique Fuentes
PCN Allergy, ORIF femur (pediatric fx), heart murmur, hyperlipidemia, GERD, L4-L5 herniated disc, chronic LBP, sciatica	Allergies	: PCN	
Presenting History:			
C/o 10/10 LBP with radiation to RLE, "feels like my leg is on fire," tachycardia, tachypnea			

Supplies	Set-up Notes: What is needed for the patient (simulator/actor) and what is needed for the patient room?
IV Set Up ☐Saline Lock ⊠ IV ⊠ IV Pump ☐Second IV Fluid Type: N/A Infusion Rate: N/A Tubing: N/A	Setting: Emergency (Use empty ER gurney in room instead of pt. bed)
Medications Medication List ketorolac (Toradol) 30mg vial omeprazole (Prilosec) 10mg tablet pantoprazole (Protonix) 10mg tablet hydrocodone/acetaminophen 5/325mg tablet oxycodone/acetaminophen (Percocet) 10/325mg tablet morphine sulfate 4mg vial Equipment: Nasal Cannula O2 Mask Non-Rebreather EMR Thermometer Accucheck NG Tube Suction Chest Tube Other Please Describe Additional Equipment Needs: O2 and SXN heads, SXN cannister with hose, AMBU device in plastic bag	Monitor Setup: □ Primary ECG Secondary ECG Pulse □ Respiratory Rate B/P SPO2 Temp CO2 Other Settings Moulage: N/A Patient Actors Requested: Age: 20s • Gender: Male (preferably Latino) • Clothing: Military fatigue pants, black tee shirt Paperwork* □ Physician Orders Chart Lab Reports *Attach Reports to the file Facilitator Notes: Nurse will receive shift report. EHR is on computer. Pain contact is accessed via EHR from VA PCP

Scenario Progression: Agitation > verbal assault > aggression > physical threats

Initial State: Frame I		Initial Patient History	
Vital Signs		Body System Assessment	Patient Finding
Cardiac Rhythm: Sinus tac	hycardia	Neurological/Sensor	Agitated, hypersensitive to touch, pressured
Pulse: 112		У	speech
Respiratory Rate: 28		Cardiac	Rapid heart rate
Breathing Pattern: labored,	rapid	Pulmonary	Rapid, labored breathing
Chest Rise: N/A		Musculoskeletal	MAE, ambulates with limp to RLE
Blood Pressure: 144/91		Gastrointestinal	N/A
SPO2: 98%		Genitourinary	N/A
General Conditions to be in	place for Scenario:	Skin/Wound	Multiple tattoos to LIE bilat
Unmade gurney, IV pole w	ith pump in room, mayo	• Skii/ would	
stand in room, thermometer unit in holder on wall, O2 and SXN heads on headboard, AMBU device in plastic bag with pull string hanging from O2 head		Vocal Complaint	10/10 LBP with radiation to RLE, "feels like my leg is on fire," requests pain medication, "I need some morphine," "I ran out of my pain meds," (if offered) "that Toradol doesn't do anything"
Correct Action: Verify patient identification	Move to Frame: 2	 Initial Lab/Diagnostics 	N/A
Wrong Action: Inform patient he will not get pain medication because he is on a pain contract.	Move to Frame: 3		
No Action:	Move to Frame: 4		

Facilitator Notes: Upon the nurse entering the room, the patient immediately complains of pain and requests pain medication in a loud voice with aggressive/exasperated tone, patient is "jumpy," moaning in between complaints, and pacing and colliding with gurney and Mayo stand.

Frame 2		Change in Patient Condition	
Vital Signs		Body System Assessment	Patient Finding
Cardiac Rhythm: Unchanged		Neurological/Sensor	Unchanged
Pulse: 112		y S	C C
Respiratory Rate: 28		Cardiac	Unchanged
Breathing Pattern: Unchanged		Pulmonary	Unchanged
Chest Rise: Unchanged		Musculoskeletal	Unchanged
Blood Pressure: 144/91		Gastrointestinal	N/A
SPO2: 98		Genitourinary	N/A
General Conditions to be in place for Scenario: Unchanged		Skin/Wound	Unchanged
		Vocal Complaint	Unchanged
Correct Action: Begin	Move to Frame: 5	New Lab Reports	N/A
removing potential weapons			
from room (e.g., IV pole) &			
initiate therapeutic			
communication and de-			
escalation techniques			
Wrong Action: Sternly inform	Move to Frame: 4		
patient to sit down and shut up/			
request urine sample for drug			
test			
No Action	Move to Frame: 4		

Facilitator Notes: Patient is increasingly agitated and is "set-off" by the nurse's insistence of "identifying him." Pt becomes increasing louder about his c/o and request for pain medication. Patient's posture is defiant and mildly threatening.

Frame 3		Initial Patient History	
Vital Signs		Body System Assessment	Patient Finding
Cardiac Rhythm: Unchanged		Neurological/Senso	Aggressive and threatening
Pulse: 130		ry	
Respiratory Rate:30		Cardiac	Rapid HR
Breathing Pattern: Huffing and r	nuffing	Pulmonary	Rapid RR
Chest Rise: N/A		Musculoskeletal	Flailing, threatening
Blood Pressure: Unchanged		Gastrointestinal	N/A
SPO2: Unchanged General Conditions to be in place for Scenario: Unchanged		Genitourinary	N/A
		Skin/Wound	Unchanged
		Vocal Complaint	"I need morphine! My leg is killing
			me! You'd better get me some pain
	1		meds or else!"
Correct Action: Begin	Move to Frame: 5	• Initial	N/A
removing potential weapons		Lab/Diagnostics	
from room (e.g., IV pole) &			
initiate therapeutic			
communication and de-			
escalation techniques			
Wrong Action: Leave room	Move to Frame: 4		
and/or confront patient			
No Action	Move to Frame: 4		

Facilitator Notes: Patient makes verbal threats and continues to be physically aggressive and threatening. Posture in confrontative and patient is flailing his arms about.

Frame 4		Change in Patient Condition		
Vital Signs		Body System Assessment	Patient Finding	
Cardiac Rhythm: Unchanged		Neurological/Sensor	Menacing, aggressive	
Pulse: Unchanged		y		
Respiratory Rate: Unchanged		Cardiac	Unchanged	
Breathing Pattern: Unchanged		Pulmonary	Unchanged	
Chest Rise: N/A		Musculoskeletal	Hyper-motoractive	
Blood Pressure: Unchanged		Gastrointestinal	N/A	
SPO2: Unchanged		Genitourinary	N/A	
General Conditions to be in place for Scenario: Unchanged		Skin/Wound	Unchanged	
		Vocal Complaint	I'm going to <i>kill</i> you if I don't get pain meds!"	
Correct Action: Call Code Grey	Move to Frame: End scenario	New Lab Reports	N/A	
Wrong Action: Try to take weapon from patient.	Move to Frame: End scenario			
No Action	Move to Frame: End scenario			

Facilitator Notes: If nurse rebukes patient, asks for urine sample in Frame 2 or confronts patient in Frame 3, patient will grab the thermometer or AMBU device's plastic bag and threaten to use it to hit or strangle the nurse. If the nurse leaves the room in Frame 3, the patient will be clearly heard shouting threats from the room.

Frame 5		Change in Patient Condition		
Vital Signs		Body	System	Patient Finding
Cardiac Rhythm: Unchanged		Assessment		
		•	Neurological/Sen	Anxious but calming down
Pulse: 101			sory	
Respiratory Rate: 22		•	Cardiac	Tachycardia, resolving
Breathing Pattern: Less labored		•	Pulmonary	Tachypnea, resolving
		•	Musculoskeletal	Unchanged
Chest Rise: N/A		•	Gastrointestinal	N/A
Blood Pressure: 128/88 SPO2: Unchanged		•	Genitourinary	N/A
		•	Skin/Wound	Unchanged
		•	Vocal Complaint	"I need something for pain."
General Conditions to be in place for Scenario: Unchanged				
······································				
Correct Action: Continue	Move to Frame: End		Now Lab Danasta	N/A
with the speutic	scenario	•	New Lab Reports	IN/A
communication & De-	sechario			
escalation techniques				
Wrong Action:	Move to Frame:			
No Action	Move to Frame:			

Facilitator Notes: Patient responds favorably to therapeutic communication and de-escalation techniques. Becomes calmer, less agitated, but admits to anxiety and pain, and repeats the request for something for pain.

Scenario Progression Algorithm: Copy and use images to create your algorithm





PATIENT CHART

Name: Fuentes, Enrique

GENDER: Cisgender	ALLERGIES: PCN	PRIMARY PHYSICIAN: Melina
DOB: 06/016/XXX		
PATIENT ID: 1234567		

Case Details:

Patient is former US Navy SEAL, honorably discharged the previous year for L4 and L5 vertebral disc herniation and persistent RLE pain. Pt has pain contract with VA PCP due to addiction to PO narcotics. Pt receives RX refill for oxycodone 10/325mg every 15 days. Pt recently refilled 8 days ago but states he is out of medication.

C/o 10/10 LBP with radiation to RLE, "feels like my leg is on fire," tachycardia, tachypnea

Shift Report:



Case Flow

Scenario

Name of Scenario: Recognizing Cues for Violence/De-escalation Patient Name: Enrique Fuentes Birthdate: 06/16/XXXX Age: 28 Allergies: PCN Ht: 5'10" Wt: 235 (106.8kg)

In-room Set Up	
No mannikin	Suction canister with tubing
Emergency room gurney	Ambu bag device in plastic bag
IV pole w/pump	Handheld temporal thermometer
Med dispense cart	Monitor to show pulse, B/P, O2, Temp
O2 and suction heads on headboard	

Summary

Situation: Young male patient presents with generalized pain. States he is on a Pain Contract through his VA PCP. Displays S/S of increased agitation. Requests pain medication beyond contract parameters. Becomes increasingly verbally assaultive and physically threatening.

Background: HPI - Patient is former US Navy SEAL, honorably discharged the previous year for L4 and L5 vertebral disc herniation and persistent RLE pain. Pt has pain contract with VA PCP due to previous addiction to PO narcotics. Pt receives RX refill for oxycodone 10/325mg every 15 days. Pt recently refilled 8 days ago but states he is out of medication. Allergic to PCN. PMH - ORIF femur (pediatric fx), heart murmur, hyperlipidemia, GERD, L4-L5 herniated disc, chronic LBP, sciatica.

Assessment: A&Ox4, anxious. C/o 10/10 LBP with radiation to RLE. States "It feels like my leg is on fire." Tachycardia and tachypnea.

Recommendation: Assess pain. Verify pain contract. Calm patient down.



Roles

- Live patient actor
- 2 student learners
- Charge nurse (if called) voiced by facilitator can't help because busy in a code
- MD (if called) can't help, not at facility

Action

Pt is "jumpy," <u>anxious</u>, and <u>pacing</u> the room as nurses arrive. Pt <u>immediately</u> complains of pain in an <u>exaggerated manner</u> and requests pain medication in a <u>loud</u> voice with exasperated and <u>angry</u> tone. Pt <u>moans</u> and glares at nurses while continuing to pace.

When nurses try to identify patient with name and birthdate, pt becomes even more angry and more loudly repeats that he needs pain medication. Pt's behavior in defiant and mildly threatening.

Pt continues to be set-off by nurses if they want to do anything other than give him pain meds. If nurses request a urine sample per pain contract, the patient becomes increasingly <u>threatening</u>.

As scenario continues patient becomes physically aggressive and threatening. Becomes confrontative.

<u>Pt script</u>

"My back is killing me, and I ran out of my pain meds. I need some pain medication now. I need morphine."

"I'm a Navy SEAL. I hurt my back in Afghanistan. I need pain meds NOW."

If offered Toradol: "That stuff doesn't do anything. I need morphine."

If asked about pain contract: "Yeah, my VA doc is pretty stingy with the pain pills. I have to go there every other week to get them. I usually run out."

If rebuked or confronted or if ask to provide a urine sample, patient grabs an object in the room and threatens to use it as a weapon.

If nurses leave room, patient loudly threatens them as the go. "Don't you turn your back on me!"

If nurses remain calm, make affirmations of support and a desire to help, patient is somewhat mollified, but flares up if they confront him, etc. Pt's behavior is <u>labile</u> and <u>volatile</u>.

Pt admits to high anxiety and pain.


If nurses all for help from the charge nurse or the MD, they are told that neither is available to help, and they just have to calm down the patient themselves.

Expected Nursing Actions

Student learners/nurse should recognize cues for potential violence, de-weaponize room, adopt nonconfrontative stance and hand gestures, and engage in therapeutic communication with de-escalation techniques.



Primary Objectives:

Debriefing Points

- 1. Recognize behavioral cues for potential violence
- 2. Formulate plan of TX incorporating patient and staff safety
- 3. Engage in de-escalation techniques
- 4. Practice therapeutic communication

Secondary Objectives:

- 1. Correctly identify patient
- 2. Recognize potential Post-Traumatic Stress Disorder
- 3. Unclutter triage/treatment room environment
- 4. Notify colleague of location
- 5. Verify pain contract
- 6. Practice refusing client requests for pain medicine
- 7. Call Code Gray Combative person
- 2. Teamwork
 - a. Who was the leader?
 - b. What were the roles
 - c. Distribute workload
 - d. Did the team have a shared mental model?
 - e. Mutual Performance Monitoring?
 - f. Communicate often enough?
- 3. CRM Principles: How did the team do?
 - a. Communicate effectively—Establish a shared mental model
 - b. Anticipate and plan
 - c. Call for Help early
 - d. Use all available resources
 - e. Use resources wisely—People and equipment
 - f. Avoid fixation errors
 - g. Use good leadership
 - h. Be a good follower
 - i. Mutual Respect
 - j. Adjust strategies under stress
 - k. Avoid and manage conflict
- 4. Patient Safety
- 5. Patient Teaching
- 6. Systems Errors
- 7. Scope of Practice

Tips for Debriefing

- 1. Learner focused
- 2. Allow enough time for learning (2-3 times the scenario length)
- 3. Focus on the process not the individual
- 4. Keep the debriefing positive



Rural SimCenter Scenario

Pt. Name: Chris Henry



Appendix B

Scenario Name: Defense of self and others during Code Silver Adapted from: RUN. HIDE. FIGHT.® Surviving an Active Shooter Event High Fidelity Low Fidelity Static Model Target Group: Student Professional Level: Advanced Intermediate Beginner Learning Objectives: Student Silver (server with server and least in the server	Learner Preparation Exercise: Review: (Insert skills or reading students should review) • RUN. HIDE. FIGHT.® Surviving an Active Shooter Event. https://www.youtube.com/watch?v=5VcSwejU2D0&t=3s • Hospital Emergency Codes: Standardized health care emergency codes for California, Hospital Association of Southern California (HASC) Safety and Security Committee. https://www.hasc.org/resource/hospital-emergency-codes Insert Scenario Summary (Basic overview of Case) Young female/male patient with life-threatening complications 2 days S/P
 5. Understand/recognize Code Silver (person with a weapon and/or active shooter and/or hostage situation) 6. Formulate plan to run (escape), hide (barricade), or fight (confront) person with weapon 7. Incorporate patient/medical condition in thinking about options Secondary Objectives: 8. Correctly identify patient 9. Recognize patient anxiety and agitation 10. Engage in therapeutic communication 11. Educate patient on Code Silver safety measures 12. Identify items in room that can be used to barricade door or used as weapons to confront person with weapon 	 appendectomy (i.e., peritonitis) on med-surg. C/O 5/10 defuse abdominal pain and fatigue. Exhibits S/S of extreme anxiety and agitation. Reluctantly and embarrassingly explains to nurses that a male family member has expressed anger about the complications and has made verbal threats against hospital personnel. Pt is concerned that family member has access to guns and has made a credible threat to "teach them a lesson" and "shoot up the place." Once information is relayed, Code Silver is paged overhead, noting the med-surg unit. Simulated gun shots are heard. Pt's anxiety and distress in increased and pt acts fearful. Total Time Duration: 70 minutes Set-up: Med-surg room; live student actor for patient Preparation: 20 minutes for pre-brief Simulation: 15-20 minutes Debrief: 30 minutes

Initial Subjective Data: (Background Information)	Patient Description and Image
Past History:	Name: Chris Henry
 <u>Past History</u>: NKDA. Reactive Airway Disease (asthma). Tonsillectomy at age 12. Closed reduction of a R ulnar FX at age 14. <u>Presenting History & TIME of DAY</u> Chris Henry is a 30-year-old admitted 2 days ago after presenting to the emergency department with acute RLQ abdominal pain (10/10), rebound tenderness, and a fever of 39.5 C. Stated pain had been going on for several days but suddenly got worse. Pt had WBC of 25. CT abdomen without contrast showed an enlarged appendix, thickened appendiceal walls, an appendicolith, and fat stranding consistent with acute appendicitis. Pt was admitted to the GI surgical service for a laparoscopic appendectomy which became an open appendectomy when the appendix burst. Pt is currently on med-surg being treated for peritonitis. Patient is NPO, has D5 1/2NS at 125ml/hr and secondary lines for ceftriaxone (Rocephin) 2gm in 100cc, and metronidazole (Flagyl) 500mg in 100cc through a SL to the R AC. Pt also has orders for IV morphine sulfate for pain PRN, IV Toradol 15mg every 8 hours, and IV Zofran PRN nausea and vomiting. 	Name: Chris HenryAge: 30Birthdate: 07/14/XXXGender: CisgenderWeight: averageHeight: averageAllergies: NKDAFiris Henry
Scenario begins at 1500 with SBAR from AM nurse to PM shift. SBAR includes mention of pt's anxiety about threatening family member.	

Supplies	Set-up Notes: For the patient (simulator/actor); For the pt. room?
IV Set Up □Saline Lock □ IV □ IV Pump □ Second IV	Monitor Setup:
Fluid Type: D5 ½ NS	Primary ECG Secondary ECG Pulse
Infusion Rate: 125ml/hr	\square Respiratory Rate \square B/P \square SPO2 \square Temp \square CO2
Tubing: Primary, Secondary for Rocephin and Flagyl hanging	Other Settings
 Medications List any medications requested for First Dose Morphine sulfate 4mg/2mg 	Moulage and Manikin: Transverse abdominal dressing available for live actor to place over low abdomen.
2. Ondansetron 4mg	Patient Actors Requested: Will be student learner participant. • A ge N/A
Equipment:	• Gender N/A
Nasal Cannula O2 Mask Non-Rebreather	Clothing N/A
\square EMR \square Thermometer \square Accucheck \square NG Tube	Relationship to Patient N/A
Suction Chest Tube Other Please Describe Additional Equipment Needs: bedside table,	Paperwork*
fire extinguisher, second IV pole, bedpan, Wheelchair	Physician Orders Chart Lab Reports
Setting: Medical	*Attach Reports electronically you'd like to show on the pt. monitor (labs, etc)
	MAR

Facilitator Notes: This scenario includes two student learners as nurses and one student learner volunteer as the scripted patient.

Scenario Progression: Admission Information

Initial State: Frame 1		Initial Patient History			
Vital Signs		Bo	ody System Assessment	Patient Finding	
Cardiac Rhythm: ST		•	Neurological/Sensory	Anxious, fearful	
Pulse: 105		•	Cardiac	Rapid consistent w/panic attack	
Respiratory Rate: 22		•	Pulmonary	Mildly tachpnic	
Breathing Pattern: Rapid		•	Musculoskeletal	Sore and extremely painful to move	
Chest Rise: Shallow		•	Gastrointestinal	Abd pain 3/10	
Blood Pressure: 105/67		•	Genitourinary	N/A	
SPO2: 99%		•	Skin/Wound	Transverse abd dressing CDI	
Temp: 37.5 C		•	Vocal Complaint	3/10 pain, concern about threatening	
General Conditions to be in pla surg set up with bedside tab and second IV pole. Other i	ce for Scenario: Normal med- ble, First Dose, IV pole and pump tems as mentioned.			family member	
Correct Action: Verify patient, abd assessment, psyhco-social assessment, take patient concerns seriously	Move to Frame: 2	•	Initial Lab/Diagnostics	Lab values, pre-op ECG, pre-op CXR, and CT abd results on chart	
Wrong Action: Ignore patient concern	Move to Frame: 2				
No Action:	Move to Frame: 2				

Facilitator Notes: Student learner patient will be scripted to be adherent with requests, etc., but will be very anxious and fearful. Pt will tell story about threatening male family member and state belief in the credibility of the physical threat of gun violence.

Frame 2		Change in Patient Condition		
Vital Signs		Body System Assessment	Patient Finding	
Cardiac Rhythm: Unchanged		Neurological/Sensory	Unchanged	
Pulse: Unchanged		Cardiac	Unchanged	
Respiratory Rate: Unchanged		Pulmonary	Unchanged	
Breathing Pattern: Unchanged		Musculoskeletal	Unchanged	
Chest Rise: Unchanged		Gastrointestinal	Unchanged	
Blood Pressure: Unchanged		Genitourinary	Unchanged	
SPO2: Unchanged		Skin/Wound	Unchanged	
Temp: Unchanged General Conditions to be in place for Scenario: Unchanged		Vocal Complaint	Pt becomes increasingly fearful when Code Silver is called. Pt states inability to get out of bed due to pain and hooked up to IV.	
Correct Action: Create plan of action to defend self and patient.*	Move to Frame: End Scenario; go over delibrations in debriefing	New Lab Reports	Unchanged	
Wrong Action: Placate patient; everything will be fine.	End Scenario			
No Action: Do not create plan.	End Scenario			

Facilitator Notes: When patient completes story of threatening family member, "Code Silver, 6th floor, med-surg" is paged overhead three times and gun shots are heard. Pt will become increasingly panicky and fearful. Correct nursing actions include: Close and lock room door and consider barricading it; Disconnect IV tubing and consider assisting patient to W/C to escape; Consider hiding in BR; Identify items in room that can be used as weapons.

Scenario Progression Algorithm: Copy and use images to create your algorithm





RURAL SIMCENTER

Debriefing Points (Instructors should develop a structured debriefing and develop questions related to:)

Primary Objectives

- 1. Understand/recognize Code Silver (person with a weapon and/or active shooter and/or hostage situation)
- 2. Formulate plan to run (escape), hide (barricade), or fight (confront) person with weapon
- 3. Incorporate patient/medical condition in thinking about options.

Secondary Objectives

- 1. Correctly identify patient
- 2. Recognize patient anxiety and agitation
- 3. Engage in therapeutic communication
- 4. Educate patient on Code Silver safety measures
- 5. Identify items in room that can be used to barricade door or used as weapons to confront person with weapon
- 1. Teamwork
 - a. Who was the leader?
 - b. What were the roles
 - c. Distribute workload
 - d. Did the team have a shared mental model?
 - e. Mutual Performance Monitoring?
 - f. Communicate often enough
- 2. CRM Principles: How did the team do?
- a. Communicate effectively—Establish a shared mental model
- b. Anticipate and plan
- c. Call for Help early
- d. Use all available resources
- e. Use resources wisely—People and equipment
- f. Avoid fixation errors
- g. Use good leadership
- h. Be a good follower
- i. Mutual Respect
- 3. Adjust strategies under stress
- 4. Avoid and manage conflict
- 5. Patient Safety
- 6. Patient Teaching
- 7. Systems Errors
- 8. Scope of Practice



Case Flow

Scenario

Name of Scenario: Code Silver: Defense of self and others

Patient Name: Chris Henry

Birthdate: 07/14/XXXX

Age: 30

Allergies: NKDA

Ht: 5'

Wt: 127 (57.7)

In-room Set Up

- No mannikin
- Medical-Surgical
- IV pole w/pump

Primary fluids: D51/2 NS @125 ml/hr

Secondary bags and tubing for ceftriaxone (Rocephin) and metronidazole (Flagyl)

Med dispense cart

O2 and suction heads on headboard

Suction canister with tubing

Ambu bag device in plastic bag

Accucheck device

Handheld temporal thermometer

Monitor to show pulse, B/P, O2, Temp



<u>Summary</u>

Situation: Young female/male patient admitted 2 days ago S/P appendectomy with life-threatening complications (i.e., peritonitis). C/o 5/10 defuse abdominal pain and fatigue.

Background: Chris Henry presented to the emergency department with acute RLQ abdominal pain (10/10), rebound tenderness, and a fever of 39.5 C. Stated pain had been going on for several days but suddenly got worse. WBC was 25. CT abdomen without contrast showed an enlarged appendix, thickened appendiceal walls, an appendicolith, and fat stranding consistent with acute appendicitis. Pt was admitted to the GI surgical service for a laparoscopic appendectomy which became an open appendectomy when the appendix burst upon being handled.

Assessment: NPO with D5 1/2NS at 125ml/hr and secondary lines for ceftriaxone (Rocephin) 2gm in 100cc and metronidazole (Flagyl) 500mg in 100cc through a SL to the R AC. Pt also has orders for IV morphine sulfate for pain PRN, IV Toradol 15mg every 8 hours, and IV Zofran PRN nausea and vomiting. PERRLA, A&Ox4, extremely anxious. C/o 5/10 defuse abdominal pain and fatigue. Transverse abdominal dressing to low abdomen (e.g., ABD pad). HRR normal, LS clear bilat, MAE. Up to BR with minimal assist.

Scenario begins at 1500 with SBAR from AM nurse to PM shift. SBAR includes mention of pt's anxiety about threatening family member.

Roles

- Live patient actor Student learner volunteer
- 2 student learners
- Charge nurse (if called) voiced by facilitator can't help because busy in a code
- MD (if called) can't help, not at facility

Pre-brief

Show Run.Hide.Fight and briefly discuss with students.

Action

Pt. exhibits S/S of extreme anxiety and agitation. Reluctantly and embarrassingly explains to the nurses that a male family member, who is a disgruntled former patient, has expressed anger about the surgical complications which he believes were similar to his experience years ago and has made verbal threats against hospital personnel. Pt is concerned that family member has access to handguns and has made credible threats to "teach them a lesson" and "shoot up the place."

Once information is relayed, Code Silver is paged overhead, noting the med-surg unit. Simulated gun shots are heard. Pt's anxiety and distress in increased and pt acts fearful.



RURAL SIMCENTER

"My stomach hurts and I'm tired."

"But I'm really worried about my Uncle Jim. He's really mad about me still being in the hospital. He says the same thing happened to him years ago, and so this must be a bad hospital. He says he's still trying to pay off his bill and he shouldn't have to because the hospital screwed up so much. He keeps sending me text messages that say he's going to teach the hospital a lesson and shoot up the place. I'm worried because he's a gun nut and has access to a lot of handguns. I'm worried he might do something stupid. I wouldn't want anyone to get hurt."

Etc.

Charge RN / MD script

If nurses all for help from the charge nurse or the MD, they are told that neither is available to help, and they just have to calm down the patient themselves.

Expected Nursing Actions

Student learners/nurse should take patient's concerns and the Code Silver seriously. They should begin to formulate a plan to defend themselves and their patient.



MEDICATION ADMINISTRATION RECORD

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NAME: Chris Henry DOB: 07/14/XXX GENDER: Cisgender PT. ID # 345-98-765 ALLERGIES: NKDA ROOM # 602 PHYSICIAN: Welby PATIENT NOTES & COMMENTS: NPO

Date: 12/3/XXXX

				•
Medication Order	Scheduled Time	Administered	NURSE INITIALS	Comments
Morphine sulfate 4mg IV prn pain 7-10	Every 4 hours PRN pain	0615 1000 1410	DH BT BT	
Morphine sulfate 2mg IV prn pain 4-6	Every 4 hours PRN pain	0330	DH	
Toradol 15mg IV 3 times a day 12/1-12/3 only	0000 0800 1600	0017 0845	DH BT	Notify MD for S/S decreased urinary output
Ondansetron hydrochloride 4mg IV prn N/V	Every 6 hours PRN nausea/vomiting	0430	DH	
Ceftriaxone 2gm IVPB	0000 0800 1600	0030 0900	DH BT	
Metronidazole 500mg IVPB	0000 0800 1600	0000 0820	DH BT	



Vital Signs

•••••

Day/time	Temp	Resp	Heart rate	BP	O2 Sat	Pain	Initials
12/3/XXXX	37.5C	22	105	105/67	99%	3	BT

NAME: Chris Henry ROOM NO: 602 PATIENT ID # 345-98-765 PHYSICIAN: Marcus Welby, MD



PHYSICIAN'S ORDERS

DRUG ALLERGIES: NKDA		NAME: Chris Henry	
		ROOM NO: 602	
		PATIENT ID # 345-98-765	
Another content	brand of drug identical in form and may be dispensed unless checked	PHYSICIAN: Marcus Welby	
1.	Admit to medical unit DX: peritonitis r/o sepsis		
2.	Diet: NPO		
3.	D5 ½ NS IV every 8 hours		
4.	Ceftriaxone 2gm IVPB every 8 hours		
5.	Metronidazole 500mg IVPB every 8 hours		
6.	Morphine sulfate 4mg IV every 4 hours PRN pain 7-1	0	
7.	Morphine sulfate 2mg IV every 4 hours PRN pain 4-6		
8.	Ketorolac 15mg IV every 8 hours X 72 hours (NOTE: 12/1/XXXX – 12/3/XXXX only)		
9.	Zofran 4mg IV every 6 hours PRN N/V		
10	0 Vital signs every 6 hours (Note: notify MD for temp > 38.5C)		
11	Up as tolerated, BRP		
12	CBC, CMP, PT/INR daily		
13	3 Lactic acid X 2 every 4 hours on admit		
14	Wound care PRN		
15			
<u> </u>	1	Physician's	
		Signature	

PATIENT CHART NAME: CHRIS HENRY ALLERGIES: NKDA PRIMARY PHYSICIAN: Marcus Welby GENDER: CISGENDER DOB: 07/14/XXXX Patie: 12/3/XXXX PATIENT ID: 345-98-765 Cases Data: Iso

Case Details:

Chris Henry is a 30-year-old admitted 2 days ago after presenting to the emergency department with acute RLQ abdominal pain, rebound tenderness, and fever of 39.5 C. Pain had been going on for several days but suddenly got worse. WBC of 22. CT abdomen without contrast showed an enlarged appendix, thickened appendiceal walls, an appendicolith, and fat stranding consistent with acute appendicitis. Pt was admitted to the GI surgical service for a laparoscopic appendectomy which became an open appendectomy when the appendix burst.

Pt is currently on med-surg being treated for peritonitis. Patient is NPO, has D5 1/2NS at 125ml/hr and secondary lines for ceftriaxone (Rocephin) 2gm in 100cc, and metronidazole (Flagyl) 500mg in 100cc through a SL to the R AC. Pt also has orders for IV morphine sulfate for pain PRN, IV Toradol 15mg every 8 hours, and IV Zofran PRN nausea and vomiting.

Shift Report:

I'm not sure if you took care of Chris yesterday but s/he's a 30-year-old who is here for a botched appy. Apparently, they tried to take it out laparoscopically, but it burst so they had to do an open and clean out the abdomen as much as possible. Anyway, Chris has had a lot of abdominal pain since surgery and is getting morphine for that as well as Toradol for pain and fever. The night nurse gave morphine right before I came on shift and I've given two more doses, the last one just about 45 minutes ago and I haven't reassessed yet. Chris is NPO and has maintenance fluids running, as well as two ABX piggybacks scheduled at 1600. SCDs were dc'd and orders are for up as tolerated. There's a transverse abd dressing that I haven't done anything with. AM labs still show an elevated white count of 17 down from 25 on admit. Electrolytes, PT/INR and lactic are all normal, so I don't know why Chris is acting so weird. Not altered or anything just really high-strung and nervous, like s/he's scared or something. You might want to find out what that's all about. Anyway, I'm off for 3 days. Any questions?

Appendix C

Informed Consent for Participation

Dear Student:

You are being asked to participate in a Quality Improvement project in NURS424. Your participation is voluntary, and you must be at least eighteen (18) years of age to participate. If you have questions or concerns about the project or your participation in it, please address them to <u>pweingartner@csuchico.edu</u> or <u>klightfoot@csuchico.edu</u>.

Purpose of the Study

The purpose of the project is to improve your readiness for nursing practice upon graduation. The project will accomplish this goal by providing you with education about and practical training in responding to and mitigating acts of verbal and/or physical aggression perpetrated by patients and others in the workplace. Workplace violence (WPV) in healthcare is a significant professional problem for nurses, one that is recognized by researchers, nurse educators, employers, domestic and international nursing organizations, and local, state, and federal governments. Persistent exposure to acts of aggression and violence puts nurses at risk for physical and emotional injuries and has been identified as a major source of absenteeism, job dissatisfaction, nurse burn-out, and attrition of the nursing workforce.

Process for Participation

Once you have provided informed consent, you will be permitted to access project materials via the Blackboard Learn course page for NURS424. You will be asked to complete several survey questionnaires during this project that solicit information about you, your selfperceptions about readiness to practice related to your understanding of WPV, and your opinions of the CSU, Chico School of Nursing curriculum related to issues of WPV. Educational materials will be provided that you will be asked to review asynchronously prior to participation in a simulation experience.

The Simulation Experience

The simulation experience will take place at the Rural SimCenter at a specified date and time for your NURS424 section. The experience will last approximately three (3) hours and include scenarios of simulated verbal and physical aggression perpetrated by patients and others as well as pre-briefing and debriefing of the scenarios. At the completion of the simulation experience you will be asked to complete a second self-perception survey about readiness to practice related to your understanding of WPV and an evaluation of the simulation experience.

Benefits of Participation

The possible benefits of participation include a better understanding of the issue of WPV in healthcare, increased ability to respond effectively to episodes of verbal and/or physical aggression in the workplace, and improvement in your readiness for nursing practice upon graduation.

Anonymity/Confidentiality

All responses to survey questionnaires will be submitted anonymously via Qualtrics and kept confidential by the primary investigator. This project is part of the primary investigator's requirements for the Doctor of Nursing Practice (DNP) degree program at San José State University. Survey responses will be used only for the purpose of the aforementioned DNP project and subsequent publication(s) and will be kept confidential.

Risks of Participation

The possible risks of participation include accidental breach in confidentiality of anonymous survey responses; negative emotional responses to the educational materials provided; physical injury during simulation scenarios (e.g., slipping, tripping, needle stick); and emotional distress triggered by scenario content and/or pre-briefing and debriefing discussions. At no time will participation in simulation scenarios result in intentional physical contact between the standardized patient(s) and students. If necessary, students can access mental health services at the WellCat Health Center at 601 Warner Street, Chico, CA 95929, or call the Health Center at (530) 898-5241 during business hours and/or the 24-hour crisis line at (530) 898-6345, prompt 2.

Voluntary Participation

Your participation in this project is completely voluntary and you may discontinue your participation at any time for any reason. Because this project is part of the clinical hour requirements for NURS424, an alternative assignment will be provided for students who decline to participate by your clinical instructor. Your choice to participate or decline to participate in this study will in no way affect your standing in NURS424 or the nursing program, in general, either positively or negatively.

Acknowledgement of Informed Consent

By agreeing to participate in this study, you acknowledge that the purpose and procedures of this project as well as the possible benefits and risks of participation have been explained to you. Additionally, you acknowledge that your participation in this project is voluntary and can be withdrawn at any time without penalty. Lastly, you acknowledge that you have been informed about who you may contact if you have questions or concerns about the project or your participation in it.

Please select one of the following:

Yes, I agree to participate. (Please click the "Mark Reviewed" button on Blackboard Learn. You will be provided access to the survey questionnaire via Qualtrics.)

No, I decline to participate. (Please contact the principal investigator at <u>pweingartner@csuchico.edu</u> and/or your course instructor for an alternative assignment.)

Appendix D

Demographic Survey Questionnaire

Dear Student,

Thank you for agreeing to participate in this important project. Please complete this questionnaire to the best of your ability. All responses are anonymous and kept confidential by Qualtrics and the primary investigator. Please address any questions or concerns you may have to <u>pweingartner@csuchio.edu</u>.

1.	What sex were you as	signed at birth?	Male	Female	Prefer not to answer	
	2	U				

2. What is your current gender identity? Cisgender Male ____ Cisgender Female ____

Transgender Male _____ Transgender Female _____

Non-binary _____ Prefer not to answer _____

3. What is your age in years? _____

4. What is your estimated current grade point average?

5. Have you had paid employment of any kind during the nursing program?

Yes ____ No ____

6. If yes, were you employed in the healthcare industry? Yes _____ No _____

7. Briefly, please share details of your work experience (e.g., title, job, etc.).

8. Have you had volunteer experience of any kind during the nursing program?

Yes ____ No ____

9. If yes, was your volunteer experience in the healthcare industry?

Yes ____ No ____

10. Briefly, please share details of your volunteer experience (e.g., organization, job, etc.).

11. How many hours per week during academic semesters do you estimate you spend studying academic subjects? _____
12. How many hours per week during academic semesters do you estimate you spend doing non-program-related paid employment? _____
13. How many hours per week during academic semesters do you estimate you spend doing non-program-related volunteering? ______
14. Have you had an experience of workplace violence, including verbal or physical aggression or assault, as a recipient or witness? Yes _____ No _____
15. If yes, please share any details of the experience you wish to:

Thank you for your participation. Your responses are appreciated!

Appendix E

Learners' Perception Survey

Dear Student,

Thank you for agreeing to participate in this important project. Please complete this questionnaire to the best of your ability. All responses are anonymous and kept confidential by Qualtrics and the primary investigator. Please address any questions or concerns you may have to <u>pweingartner@csuchio.edu</u>.

Please indicate your level of agreement with the following statements.

(SD = strongly disagree, D = disagree, UD = undecided, A = agree, SA = strongly agree)

1. I have the knowledge needed to manage aggressive or violent patient behaviors.

SD D UD A SA

2. I have the skills needed to manage aggressive or violent patient behaviors.

SD D UD A SA

3. I have the ability to manage aggressive or violent patient behaviors.

SD D UD A SA

4. I feel confident I can manage aggressive or violent patient behaviors.

SD D UD A SA

5. I feel prepared to manage aggressive or violent patient behaviors.

SD D UD A SA

Appendix F

Effectiveness of WPV Curriculum at CSUC School of Nursing Survey Dear Student,

Thank you for agreeing to participate in this important project. Please complete this questionnaire to the best of your ability. All responses are anonymous and kept confidential by Qualtrics and the primary investigator. Please address any questions or concerns you may have to <u>pweingartner@csuchio.edu</u>.

Please indicate your level of agreement with the following statements.

(SD = strongly disagree, D = disagree, UD = undecided, A = agree, SA = strongly agree)

1. The topic of workplace violence is effectively presented in theoretical/lecture courses in the CSU, Chico School of Nursing curriculum.

SD D UD A SA

The topic of workplace violence is effectively presented in clinical courses in the CSU,
 Chico, School of Nursing curriculum.

SD D UD A SA

The topic of workplace violence is effectively presented in simulation courses in the CSU,
 Chico, School of Nursing curriculum.

SD D UD A SA

4. Students would benefit from more workplace violence content in theoretical/lecture courses at CSU, Chico, School of Nursing.

SD D UD A SA

 Students would benefit from more workplace violence content in clinical courses at CSU, Chico, School of Nursing.

SD D UD A SA

 Students would benefit from more workplace violence content in simulation courses at CSU, Chico, School of Nursing.

SD D UD A SA

Appendix G

WPV PowerPoint Presentation



Student Learning Objectives

By the end of this presentation, the learner will be able to:

- Understand the magnitude and gravity of workplace violence (WPV) in health care
- 2) Identify some of the risk factors for and workplace responses to WPV
- 3) Discuss professional and personal consequences of WPV for nurses, the nursing profession, and healthcare facilities
- Recall strategies for mitigating WPV, including identifying precursors to violence, de-escalation of aggressive behavior and therapeutic communication, and defense of self and others
- 5) Recognize the value of simulation training in mitigating workplace
- violence
- 6) Define participant expectations and safety considerations for simulation training



Nursing is a dangerous profession. Nurses are at risk for exposure to contagious diseases and hazardous substances used to treat illnesses and injuries, and other work-related dangers like falls, back injuries, and accidental needlesticks. Perhaps most egregiously, every clinical nurse is at risk of becoming the victim of workplace violence (WPV) perpetrated by patients and others. No matter what department nurses work in or their nursing specialty, exposure to threats of physical, emotional, and psychological injury is a pervasive problem and something every new nurse should be aware of and know how to mitigate. Nursing students are expected to be familiar with many skills and areas of knowledge in order to be ready for professional nursing practice. We believe that knowing, about VMPV and practicing skills to inhibit it, manage it when it occurs, and mitigate its effects should be an essential component of nursing education. It is the purpose of this experience.

What is WPV?

...the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on dutv.

~ The National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Prevention and Control (CDC) ...incidents where staff are abused, threatened or assaulted in circumstances related to their work...involving an explicit or implicit challenge to their safety, well-heine or health

~ The World Health Organization (WHO)



Prevalence & Demographics

- According to the U.S. Bureau of Labor Statistics, 20,870 workers in private industry experienced trauma from nonfatal workplace violence in 2019. These incidents required days away from work.
- Of those who experienced trauma from workplace violence:
 - 68% were temale
 - ▶ 65% were aged 25 to 54
 - 70% (14,609) worked in healthcare and social assistance industries
 - ▶ 20% required 3 to 5 days away from work to recover
 - \blacktriangleright 21% required 31 or more days away from work to recover

Prevalence & Demographics (cont)

According to Occupational Safety and Health Administration (OSHA), between 2002-2013, WPV requiring workers to take days away from work for treatment or recovery was **four times** more prevalent in the healthcare industry than in all other industries.

In 2013, healthcare and social assistance sectors experienced **7.8** incidents of WPV per 10,000 full-time employees compared to two incidents per 10,000 full-time employees in all other industries.

Using data from the American Nurses Association's (ANA) Health Risk Appraisal (2014), OSHA also reports that half of all registered nurses and nursing students were verbally abused in 2013 and 21% were physically assaulted (OSHA, 2015).













Patient	Staff	Environment
STAMP behaviors (Staring, tone or volume of volce, anxiety, mumbling, pacing)	Lack of recognition of dangerous situations	Lack of facility policies and staff training
Escalating aggression	Little or no use of de-escalation skills or training	Patient boarding and long wait times, crowded conditions
History of violence	Inadequate security	Poorly lit, isolated areas, small exam rooms, noisy environment
Alcohol and/or drug use	Inadequate staffing ratios	Unrestricted public access
Presence of firearms, knives, or other weapons	Pain or other physical symptoms, disability	Culture of tolerance
Emotional state	Lack of confidence in handling difficult patients	Inadequate safety controls
Type of diagnosis	Ufting, moving, and transporting patients	Poor environmental design that may block vision or escape routes
Gang activities	Working alone	Lack of means of emergency communication
	Lack of support	Working in neighborhoods with high crime rates
		High worker turnover



Workplace Responses

- WPV is acknowledged and condemned
- Zero tolerance p
- Video surveillance
- WPV education and mitigation training
- Support for employees who report assaults
- Mandatory reporting in a Just Culture (e.g., "no-fault") conte



Consequences of WPV

- In addition to the possibility of significant physical injury, WPV results in Nurses feeling unsafe at work (Burchill, 2015).
- Decreased "resilience" of nursing staff and increased "burnout" (Rees et al., 2018)
- "Emotional exhaustion" among nurses (Wolf et al., 2017)
- Lost productivity, decreased ability of nurses to provide quality patient care, and attrition of the nursing workforce (Wolf et al., 2014).
- Increased absenteeism (Edward et al., 2014);
- Significant financial costs to employers (Brous, 2018

Strategies for Mitigating WPV: Identifying Precursors to WPV

Observable Behavior	Assessment Cue(s)
Staring and eye contact	Prolonged glaring; culturally-variable absence of eye
Tone and Volume of Voice	Sharp or caustic retorts; Sarcasm; Demeaning inflection; Increase in volume
Anxiety	Flushed appearance; Hyperventilation; Rapid speech; Dilated pupils; Physical indicators of pain (grimacing, writhing, clutching body); Confusion and disorientation; Expressed lack of understanding about hospital processes
Mumbling	Talking 'under their breath'; Criticizing staff or the institution just loudly enough to be heard; Repetition of same or similar questions or requests; Slurring or incoherent speech
Pacing	Walking around confined areas such as waiting room or bed space; Walking back and forth to the <u>nurses</u> area; Flailing around in bed; 'Resisting' health care

Strategies for Mitigating WPV: Risk Assessment I

- Aggressive Behavior Risk Assessment Tool (ABRAT) (Kim et al., 2011): a set of items that best predict violent behaviors.
- Ten items: Positive predictor variables of violent events

Physically aggressive/threatening	Anxiety
History or signs/symptoms of mania	Agitation
History of physical aggression	Mumbling
Confusion/cognitive impairment	Staring
Threatening to leave	Shouting/Demanding







Strategies for Mitigating WPV: **De-escalation**

De-escalation is the use of verbal and nonverbal communication skills aimed at defusing patient anger and stopping aggression. It includes verbal and physical expressions of empathy, creating a therapeutic alliance with patients, and nonconfrontational limit-setting based upon respect (Rabenschlag et al., 2019).

Flexibility in de-escalation approach is important because what might be a successful approach for one patient could be inflammatory to another (Robbins, 2019).

Strategies for Mitigating WPV: **De-escalation**

Three steps to de-escalation

- Verbally engage patient
 Establish a collaborative, therapeutic relationship
- Four objectives

 - Help the patient manage emotions and distress and maintain or regain control of behavior What the patient does is of more importance than how they feel

Strategies for Mitigating WPV: **De-escalation**

- Associated motor activity is usually repetitive and non-goal directed.
- Repetitive thoughts are exhibited by vocalization
- Agitation exists on a continuum from anxiety to agitation to aggression.

Strategies for Mitigating WPV: **De-escalation**

- Staff should be appropriate for the job

 1)
 Staff must have a good attitude, starting with a positive regard for the patient and the capacity for empathy.

 2)
 Staff must recognize that the patient is doing their best but having difficulty

- star must recognize that indeparent is doing there best out having officulty
 Starf must recognize that indeparent is doing there best out having officulty
 Starf must recognize that indeparent intellectual detaility or offer partent's tect of the skills needed to get their needs met (e.g., personality disorder).
 Staff should be adequately trained
 De exclusion often results in a verbal loop: Staff listens to the patient's tect of the patient to do (e.g., accept medication, and states what staff need the patient to do (e.g., accept medication, sit down, etc.)
 The loop may repeat ited its staff again listen to the patient. Staff may have to repeat a message a dozen times or more before it is heard by the patient.
- ~ Richmond et al. 2012



Mitigating WPV: Clinical Tips

Tip #1: Ensure safety

- A. Safety is the **first** priority. Safety of the patient and the nurse.
- B. Ask yourself: Do I feel safer
- C. Do not ignore reenings of being t
- D. Communicate your location and activity to a colleague: "I'm going to treatment room X to take the patient's vital signs. The patient has been agitated."
- E. Look for warning signs (cues) for agitation STAMP
- Rationale: You cannot help your patient if you feel unsafe.

Mitigating WPV: Clinical Tips

Tip #2: Assess treatment area

- Know entry and exit doors; do not close door Position yourself between the patient and door without giving the patient the impression you are blocking their egress
- B. Be aware of items in the room that can be used as weapons Bedside tables, IV poles, wall-mounted monitoring equipment (e.g.,
- C. Stand two arm lengths away from patient whenever possible
- D. Avoid turning your back on the patient

Rationale: A quick exit may help you avoid injury; maintaining distance from the patient may avoid being struck or kicked

Mitigating WPV: Clinical Tips

Tip #3: Assess you attire and tools

- Avoid wearing loose clothing that can be grabbed or used as a weapon (e.g., scarf)
- B. Avoid wearing lanyards and stethoscopes around your neck, hemostats clipped to scrubs, pens in shirt pockets, etc.
- C. Avoid wearing jewelry that can be pulled (e.g., necklaces, dangling earrings and bracelets)
- D. Avoid open-toed shoes and footwear that is difficult to run in (e.g., backless clogs)

Rationale: Reducing potential weapons and increasing mobility may prevent injury from an erratic, labile, and volatile patient.

Mitigating WPV: Clinical Tips

- Tip #4: Limit interactions with agitated/aggressive patients
- A. Only one person who is trained in de-escalation techniques should communicate/interact with agitated patient
- B. Redirect bystanders/others away from patient treatm
- C. If possible, minimize number of family/friends with the patient; if necessary, ask visitors to leave; ensure patients and other that you will keep them informed without violating HIPAA
- D. Maintain a calm, distraction-free environment (e.g., limit interruptions, television)
- E. Separate anyone from the patient who verbally antagonizes them or increases their agitation/hostility.

Rationale: Agitation can be exacerbated by increased external stimuli.

Mitigating WPV: Clinical Tips

Tip #5: Treat agitated patients with dignity and respect

- A. Speak and behave in a nonthreatening, nonchallenging manner.
- B. Be polite and courteous
- C. Use empathetic statements. Rather than ask "What's making you angry" make an empathetic statement: "It looks like X really has you upset." This encourages patient self-reflection.
- D. Avoid stiff, stern, and nonchalant postures (e.g., hands on hips, arms crossed over chest, hands in pockets, slouching). Keep hands open and visible.
- E. Stand at an angle to the patient so as not to appear confrontational. Maintain eye contact without staring/glaring.

Rationale: Being respectful facilitates therapeutic trust.

Mitigating WPV: Clinical Tips

Tip #6: Verbal de-escalation: Essential Tools!

- A. Speak calmly in a volume, tone, and rate lower, softer, and slower, respectively, than the patient. *This reduces auditory stimuli*.
- B. Ask the patient their preferred name and use it. When speaking of others, use proper nouns (e.g., "Mary") rather than title or status (e.g., "your boos," "your wife"). This personalizes the encounter.
- C. Adopt a non-prejudicial "not-knowing" stance and ask questions with genuine interest. *This shows sincerity and helpfulness.*
- D. Avoid using medical terminology and acronyms/abbreviations. This evens the field between you and the patient.

Mitigating WPV: Clinical Tips

- E. Give the patient simple, concrete directions. *Complex or step-wise instructions are difficult to process when agitated.*
- F. Reward patient compliance by saying "Thank you," "I appreciate that you are keeping in control." This is a sign of respect.
- G. Makes statements about your openness to listen, willingness to help, etc. This helps create a collaborative, therapeutic environment.
- you saying is...". This provides the patient a sense of being heard as well helps them reflect on their state of mind.

Mitigating WPV: Clinical Tips

- Use non-judgmental, open-ended questions/statements (e.g., "Tell me more about that." "Can you elaborate on that?")
- J. Preface sensitive questions with a rationale for asking them. This demonstrates recognition and appreciation of the patient's vulnerabilitv.
- K. Avoid making assumptions, especially about how the patient feels.
- L. Avoid arguing with the patient about the current situation.

Mitigating WPV: Clinical Tips

Tip #7: Provide choices to the patient

- B. Within reason and when appropriate, use tactful bargaining with patient to increase compliance.
- C. Set limits.
- D. Choose wisely what you insist the patient *must* do. Avoid creating a situation in which patient adherence is the only way to avoid a

Mitigating WPV: Clinical Tips

Tip #8: Help the patient regain control

- A. Avoid telling patients to "calm down." Doing so implies a dominant-submissive relationship.
- breaths").
- C. Ask patients what helps them calm down and, if possible, attempt to provide it.





Some comments on simulation

- Being a nurse is like playing a part in a movie. You know what to do and say because you have read the script and because you have practiced and rehearsed.
- Clinical simulation is the process of practicing being a nurse in an environment where risks to "patients" and "nurses" are minimized.
- This simulation experience will include two scenarios that simulate patient agitation/aggression and workplace violence. Both scenarios will incorporate live patients (i.e., not mannikins). The patients will be "standardized" in that they will engage in scripted behavioral and verbal responses. Some variation in actual behavior and verbiage may

Some comments on simulation: How to prepare

- Practice the skills of verbal de-escalation provided in Clinical Tip #6
 above. Think of these as part of the script of nursing.
- Reflect upon the healthcare facilities where you have completed clinicals over the last five semester. Were these safe places to practice? If yes, what do you think made them safe? If not, why do you think they were unsafe?
- Please arrive at the SimCenter well-rested and eager to participate

Some comments on simulation: Ground **Rules**

- Standardized patients (SPs) are instructed not to make harmful physical contact with student learners. Customary, being physical contact (e.g., shaking hands) is permitted.
- Avoid making harmful physical contact with SPs (e.g., physical restraint application).
 Professional, benign physical contact (e.g., palpating pulses, auscultating) is permitted.
- If at any time during a simulation experience you feel unsafe or uncomfortable and want to discontinue your participation, use the word CUS to indicate the need to stop.



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