INPATIENT PSYCHIATRIC HEALTHCARE WORKER AND ADMINISTRATOR PERCEPTIONS OF WORKPLACE INTERVENTIONS FOR PATIENT-ON-STAFF ASSAULT

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

SUSAN PARNELL, B.S.N., M.S.N., M.P.H.

DENTON, TEXAS

DECEMBER 2012

TEXAS WOMAN'S UNIVERSITY

DENTON, TEXAS

November 7, 2012

To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Susan Parnell entitled "Inpatient Psychiatric Healthcare Worker and Administrator Perceptions of Workplace Interventions for Patient-on-Staff Assault." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Nursing.

Rebecca Krepper

Rebecca Krepper, Ph. D., MBA, Major Professor

We have read this dissertation and recommend its acceptance:

Rita Dellostritto

Dr. Rita Dellostritto, Ph.D.

Lene Symes

Dr. Lene Symes, Ph.D.

Karen C. Lyden

Associate Dean

Accepted:

Interim-Dean of the Graduate School

ACKNOWLEDGMENTS

I would like to thank the chair of my committee, Dr. Rebecca Krepper for working with me and offering kind and thoughtful guidance on my research. In addition, I would like to thank my committee members, Dr. Rita DelloStritto and Dr. Lene Symes, for their commitment to this dissertation. I appreciate your efforts and encouragement very much.

A special thanks to the University of Texas Health School of Nursing (UTHSON) and the staff and administrators at University of Texas Harris County Psychiatric Center (UTHCPC) for the many years of occupational health and safety projects that helped form my interest in patient on staff assault as a preventable event. I am grateful for the exemplary leadership of Ms. Lois Moore, Dr. Thomas Mackey, and Dr. Robert Emery. I appreciate your warm reception to these projects and delight in our past successes. I am looking forward to working with UTSON and UTHCPC in the future.

Finally, thanks go to my husband and children for your tolerance and understanding of this endeavor and the many other projects that make my life interesting. I look forward to supporting each of you in chasing your dreams. I love you all.

ABSTRACT

SUSAN PARNELL

INPATIENT PSYCHIATRIC HEALTHCARE WORKER AND ADMINISTRATOR PERCEPTIONS OF WORKPLACE INTERVENTIONS FOR PATIENT-ON-STAFF ASSAULT

DECEMBER 2012

Psychiatric personnel as an occupational group are among the highest risk for experiencing assault at work. Existing literature is primarily quantitative with a descriptive focus on numbers and types of injuries and environmental factors associated with these assaults. A qualitative study using descriptive interpretation theory was conducted to identify clinical interventions that might prove effective in reducing these assaults. Seven direct care providers and seven administrative leaders were recruited from three inpatient psychiatric specialty hospitals and one general hospital with a psychiatric specialty unit located within Harris County, TX. Using a semi-structured interview, perceptions of inpatient psychiatric personnel and administrators regarding policies and processes in place to prevent, address, and monitor assault were explored. Themes that were identified dealt with precursors to assault, intervention strategies and organizational and staff descriptors. The findings that emerged from the analysis of the data as well as a review of existing policies and procedures used in psychiatric facilities related to patient assault spoke strongly to what organizations could do to prevent assaults. These preventive measures included the need for a comprehensive plan for staff safety, formal

opportunities for communication between direct care providers and administration, attention to staffing patterns, ensuring staff's competence with early recognition of agitation and aggression, and a process that ensures timely orders from the physician for medication, seclusion and restraint.

TABLE OF CONTENTS

LIST OF TABLES

Table Page

LIST OF FIGURES

Figure Page

CHAPTER I

INTRODUCTION

The United States Bureau of Labor and Statistics (BLS) found that nearly 5% of workplaces in the United States had reported an incidence of workplace violence in 2005 (United States Department of Labor and Statistics, 2006). In workplaces that have experienced assault, reported effects include an increase in absenteeism, turnover, and fear levels, and a decrease in productivity and morale. Among healthcare workers, the United States Bureau of Labor and Statistics (BLS) reported 69 homicides among healthcare workers between 1996 and 2000 (Duhart, 2001) While death from assaults on healthcare workers is rare, the incidence of non-fatal injuries in healthcare workers accounts for 48% of non-fatal injuries reported from occupational assault and violent acts among all professions. The BLS indicates that nurses, nurse aides, orderlies and attendants suffer the most injuries due to assault. Within nursing, The Minnesota Nurses' Study reported the risk of assault to be more than two times greater for nurses working in emergency and psychiatric settings (Gerberich et al., 2004). The average annual rate of non-fatal violent crime for all occupations is 12.6 per 1,000 workers; however mental healthcare workers greatly exceeded this average with 68.2 assaults per 1,000 annually. The BLS warns that these numbers may be lower than the actual incidence due to the perception within the healthcare industry that assaults are a part of the job (Duhart, 2001).

A Federal Bureau of Investigation (FBI) report indicates psychiatric personnel are among the workers at highest risk of assault by a patient or someone receiving a service (Duhart, 2001). The experience of being assaulted is pervasive among mental healthcare workers. Their risk of assault by a patient is two and one-half times that of other healthcare workers. Types of physical assault on staff includes being hit, bit, pushed, or otherwise injured by the patients to whom they provide care (Gerberich et al., 2004; Little, 1999). The severity of the injury is usually not life threatening, but the emotional impact can be devastating (Wykes & Whittington, 1998).

Most assault injuries result from being hit (48.2%), overexertion (20.0%), being kicked (1.2%), being struck against an object (3.5%), and being bitten (3.5%) (Bensley, Nelson, Kaufman, Silverstein, & Shields, 1997; Duxbury & Whittington, 2005). Nurses in psychiatric specialties who experience physical and/or emotional injury claim a lack of confidence in their hospital administrations to change their working environments and, in some cases, make a change in employment or leave nursing entirely (Flannery & Walker, 2003; McKenna, Poole, Smith, Coverdale & Gale, 2003; Wykes & Whittington, 1998). Many psychiatric personnel assaulted by patients harden themselves to the experience with 45% of these workers reporting that being assaulted is a part of their job (Gerberich et al., 2004).

Patients and staff have different perspectives as to the source of conflict. Patients attribute violence to being provoked by another patient or staff, being ignored by staff, or family conflicts (Ilkiw-Lavalle & Grenyer, 2003). Staff, however, are more likely to

focus on medical issues such as the patient's state of illness, level of acuity, and insufficient medication (Bensley et al. 1997; Duxbury & Whittington, 2005; Ilkiw-Lavalle & Grenyer, 2003). In addition to staff and patient factors, organizational issues factor into the likelihood of assault. Facility conditions are important to maintaining a therapeutic milieu and reducing sources of stress and conflict. Conditions associated with increased patient-on-staff assault include: over-crowding, excessive noise, decreased privacy, off temperature or poor quality food, and temperature of the patient care unit (Bensley, Nelson, Kaufman, Silverstein & Sheilds, 1995). The lack of adequate programming such as music therapy or group meetings could also contribute to violence from patients toward staff.

Organizational roles are more traditionally perceived as administrative responsibilities such as developing policies and procedures for patient care including those intended to reduce patient-on-staff assault. Hospital policies related to smoking, seclusion, and restraint have been shown to increase conflict leading to assault (Bensley et al., 1995; Duxbury & Whittington, 2005). In addition to policies and procedures, the organization is responsible for providing adequate training programs and staffing to safely manage patients. Lack of staff experience and training significantly impact the incidence of patient on staff assault (Bensley et al., 1995). Descriptive studies have illuminated these issues but there is a lack of information on how these organizational issues relate to the individual assault experience.

Purpose of the Study

In light of the evidence of assault as a prevalent problem in inpatient psychiatric settings, there is an urgent need to examine institutional policies in place meant to prevent, address and monitor workplace assault (Centers for Disease Control & Prevention, 2002). It is critical that organizations analyze the effectiveness of initiatives aimed at managing assault. Quality initiatives should extend beyond monitoring numbers and types of assaults to evaluating the effectiveness of administrative controls intended to prevent and monitor assault in the organization. In this study, institutional policies regarding patient-on-staff physical assault were explored from the perspective of psychiatric healthcare workers who have experienced assault.

This study described how inpatient psychiatric personnel who have experienced assault by a patient and administrators who are responsible for a safe work environment perceived the institutional policies to prevent, address and monitor assault. An interpretive description framework was used to explore this issue. Through structured interviews, the psychiatric personnel were asked to reflect on their most recent assault experience to better understand the perceptions of inpatient psychiatric personnel and administrators regarding institutional policies.

Rationale for the Study

Despite heightened awareness of workplace assault, the number of assaults on inpatient psychiatric personnel remained high. While epidemiologic literature provided

an account of the incidence and prevalence of assault and the nature of the injury, there had been no in depth studies to identify specific occurrences that might potentiate violence. More than two-thirds of psychiatric personnel will experience an assault by a patient during their career (Ito et al., 2001; Whittington, 2002; Wykes & Whittington, 1998).

Non-fatal assaults on psychiatric personnel occur at a rate five-fold higher than the average rate of assault among all professions in the United States. The most commonly reported injuries are physical injuries due to blows, bites, and over exertion, however, many of these workers experience deleterious effects following assault that lead to employment issues including job dissatisfaction, burnout, and intention to leave their job (Ito et al., 2001; Whittington, 2002; Wykes & Whittington, 1998).

In surveys of staff perceptions regarding causation of assault reveal contributing factors that indicate poor administrative controls from the organization, including: high patient-to-staff ratios, highly inexperienced staff to experienced staff ratios, lack of staff training, patterns of insufficient patient medication, noisy patient care environment and a lack of personal privacy (Bensley, et al., 1995; Grassi, Peron, Marangoni, Zanchi, & Vanni, 2001; Ilkiw-Lavalle & Grenyer, 2003; Owen, Tarantella, Jones, & Tennant, 1998). Organizations such as the Joint Commission have focused performance improvement programs on patient assault; however, these are viewed from the perspective of patient safety rather than workplace safety (Joint Commission E-dition (2011). Furthermore, the work practice controls described by the Joint Commission

standards are not specific to psychiatric specialty hospitals. All hospitals classified as "acute care" have the same standards whether they are a general hospital or a specialty hospital.

Well-known organizations related to occupational health and safety have heightened awareness regarding the problem of assault on psychiatric healthcare workers including, the United States Occupational Safety and Health Administration (US-OSHA) and the National Institute for Occupational Safety and Health (NIOSH) (CDC, 2002; US-OSHA, 2004). While no regulatory standards have been issued for healthcare agencies to mandate assault reduction strategies, US-OSHA and NIOSH have issued guidance documents recognizing assault as a serious form of workplace violence.

The California Occupational Safety and Health Administration (Cal-OSHA) recently took a stern approach to workplace assault by citing two hospitals, Patton State Hospital and Atascadero State Hospital, with inadequate staff protection against injuries that led to an average of 20 assaults per month at Patton and an average of eight assaults per month at Atascadero (Hospitals Fined, 2012). Cal-OSHA reported the injuries included severe head trauma, fractures, contusions, lacerations, and bites. Fines were levied against each institution: $57,400 against Patton and $38,555 against Atascadero. This unprecedented move comes two years after a psychiatric technician was killed by a patient at the Napa State Hospital in California.

Professional nursing organizations have recognized assault on psychiatric healthcare workers as a serious problem and have offered suggestions for improved

safety (CDC, 2002; Love & Morrison, 2003). For example, the *American Academy of Nursing Expert Panel on Violence Policy* published a list of recommendations such as the elimination of psychiatric healthcare worker exposure to violence through worksite engineering and administrative controls (Love & Morrison, 2003). In addition, the American Association of Occupational Health Nurses (AAOHN) has formed an alliance with US-OSHA to educate and assist employers in the prevention of workplace violence (US-OSHA, 2007). These types of initiatives from professional organizations draw attention to the importance of managing assaults in the psychiatric healthcare environment.

Philosophical Orientation

The philosophical orientation of this study was interpretive description based upon the naturalistic paradigm in which the focus was to understand the object of interest as accessed through subjective interactions with the object (Lincoln & Guba, 1985; Polit, Beck, & Hungler, 2001). The naturalistic paradigm assumes that people perceive the world differently and that reality differs according to perceptions (Agostinho, 2005). Reality may have multiple points of view and can change over time. Knowledge, within the naturalistic paradigm, is increased by involvement of the researcher with the study participant (Creswell, 1998). Close interactions with the participant, including the voices and interpretations, are the primary way to access knowledge of the object under investigation. Naturalistic inquiry is a method and philosophy well suited to clinical problems, such as assault. The approach allowed for the voices of assaulted healthcare

workers and administrators to be heard and used as a source of data that could fully describe the events surrounding assault and the adequacy of organization's administrative controls to prevent assault. The research outcomes contributed to nursing knowledge and provide other opportunities for nursing inquiry and research.

Fit of Naturalistic Paradigm

Lincoln and Guba (1985) describe the criteria to determine an appropriate fit of the naturalistic paradigm to the focus of the study. A set of basic beliefs called axioms, posed as questions; guide the researcher to a conclusion about appropriate fit. The five axioms from Lincoln and Guba (1985) to determine appropriateness are:

1. Is the focus of inquiry represented by numerous complex constructions?
2. What is the level of interaction between the investigator and the focus of inquiry and will the interaction introduce indeterminacy into the interaction?
3. What is the level of context dependence?
4. Is it reasonable to ascribe causal relationships to the outcome?
5. Will values affect the outcome of the inquiry? (p. 36-38).

A positivist inquiry, such as a chemistry experiment, would have rigid and complex construction with a minimal level of interaction between the investigator and the experiment, and with little uncertainty about the outcome (Lincoln & Guba, 1985). The position and demeanor of the researcher would have little effect on the outcome of the experiment and it is unlikely that the researcher's values could alter the outcome of the study because a chemical reaction has a straightforward cause and effect outcome. In

contrast, if the focus of the study is behavioral or social in nature, the answers to the axioms are likely to indicate less rigid construction with a high level of researcher involvement, including the influence of the researcher's values, and variability in outcome without a causal relationship (Creswell, 1998; Lincoln & Guba, 1985). These types of behavioral or social inquiries, including interpretive description, are well suited to naturalistic inquiry.

Interpretive Description

Research questions relevant to naturalistic paradigm and descriptive interpretation are clinical problems, program evaluation, and policy analysis (Lincoln & Guba, 1985; Thorne, 2008). The purpose of the research question is to resolve a problem caused by two or more factors resulting in a conceptual problem, an action problem, or a value problem. The proposed study explored the problem of assault within the context of the clinical realm of nursing. Healthcare staff and administrators were asked open-ended questions regarding assault and administrative controls, such as programs and policies to construct knowledge about the efficacy and adequacy of institutional measure to prevent assault.

Interpretive description was the theoretical basis for this research because it provided a naturalistic framework for knowledge generation that allowed the researcher to explore descriptive research questions about a relevant clinical issue (Thorne, 2008). This qualitative research method was applied for two purposes of inquiry: reaching a practice goal and gaining an understanding of what is known and not known by empirical

evidence (Thorne, 2008). Interpretive description has elements of both objective neutrality and unconventional theorizing to develop an understanding of practical, applied situations. The interpretive description methodology develops an understanding of complex experiential clinical phenomena to answer questions from the nursing practice level.

The interpretive description method of knowledge generation is not clearly aligned with the traditional qualitative methodologies of phenomenology, ethnography, or grounded theory. These traditions have origins that make assumptions about knowledge and the creation of knowledge that do not apply to interpretive description. Thorne (2008) also noted that traditional qualitative methods do not work well as a primary research method for applied and professionally motivated generation of knowledge. The interpretive description theory was developed out of a need for an applied qualitative research approach to address experiential clinical issues within nursing practice. Prior to interpretive description theory, qualitative researchers were obliged to produce studies within one of the traditional qualitative models or risk criticism that the research method was "sloppy," "mixed method," or "method slurring" (Thorne, Kirkham & MacDonald-Emes, 1997). Some of the qualitative research in question was un-named, legitimate qualitative research involving description and interpretation about a shared experience from the perspective of those who lived it (Thorne, Kirkham & MacDonald-Emes, 1997).

The focus and context of this study dealt with a complex experiential clinical event within nursing; assault on psychiatric healthcare staff. Interpretive description provided a

logical, systematic, and defensible framework for the researcher to engage the assaulted psychiatric healthcare staff members and administrators and to assess knowledge regarding assault that was assumed, established, and yet to be identified (Thorne, 2008). The development of new knowledge regarding the subjective, experiential, tacit, and patterned aspects of assault were intended to gain a contextual understanding to guide future evidence-based application to the lives of psychiatric healthcare staff. The use of interview questions and probes produced multiple angles of vision recognizing that the subjective experiences of assaulted psychiatric healthcare staff resulted in many different truths meant to grasp an understanding of the program and policy needs of psychiatric healthcare staff and develop a sensitivity around them.

Research Questions

The purpose of the research was to examine the perceptions of inpatient psychiatric personnel and administrators of inpatient psychiatric centers regarding institutional policies in place to prevent, address, and monitor workplace assault. The primary research questions addressed by this study were:

1. What are the perceptions of inpatient psychiatric personnel regarding institutional policies in place to prevent, address, and monitor assault?
2. What are the perceptions of administrators regarding institutional policies in place to prevent, address, and monitor assault?

The sub-questions questions for the inpatient psychiatric personnel interview were:

1. In the context of the last assault you experienced, what were the events leading up to the assault?
2. How did the assault event end?
3. How was the assault event reported?
4. What are your expectations and/or suggestions for administration?

The sub-questions for the administrators of inpatient psychiatric centers interview were the following:

1. In the context of the last assault that you managed, what were the events leading up to the assault?
2. How did the assault event end?
3. What was the process for reporting the event?
4. What policies, training or other safeguards were in place to prevent, address or monitor assault?

Limitations

The focus of this study was to describe inpatient psychiatric personnel and administrators of inpatient psychiatric centers' perceptions of institutional policies in place to prevent address and monitor workplace assault. Limitations of the study included (a) selection of participants from a localized geographic area; (b) the potential for bias based upon the researcher's role as an administrator in two large institutions with inpatient psychiatric care; and (c) use of a volunteer sample who agreed to share their

thoughts and experiences, possibly excluding participants who were unwilling to participate or uncomfortable about participating in the interview process.

Summary

The descriptions of the frequency and severity of patient-on-staff assault on psychiatric personnel highlight the importance of protecting workers from this well-described workplace hazard. Reports from the literature show that high rates of assault among psychiatric personnel span over two decades without change. Growing concern exists among regulatory agencies and professional nursing organizations; however, evidence-based interventions to address assault are lacking. Administrative controls aimed at reducing or eliminating assault are in place but their effectiveness has not been evaluated. The descriptive interpretation design of the study is well suited to examine clinical practice goals and to qualitatively examine what is known and unknown about issues from the practice settings.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of the research was to examine the perceptions of inpatient psychiatric personnel and administrators of inpatient psychiatric centers regarding institutional policies in place to prevent, address and monitor workplace assault. Studies have described staff perceptions of assault in terms of causes and management of aggression (Cunningham, Connor, Miller, & Melloni, 2003; Rossberg, & Friis, 2003). These reports list issues that have an organizational component such as policies, training, or communication; however, little has been published examining the effectiveness of organizations at conveying support to assaulted workers (Calabro & Baraniuk, 2003). Organizational support is a key factor in the perceived safety climate as well as staff retention (Calabro & Baraniuk, 2003; Dejoy, Schaffer, Wilson, Vandenberg, & Butts, 2004). This review of the literature examined the incidence and outcomes associated with assault and reviewed assault literature for organizational opportunities to support assaulted workers. These support opportunities provided the foundation for a qualitative investigation of assault from a new perspective.

The search for literature was conducted using computerized databases and hand searches to find pertinent literature. PsychInfo, Medline, PubMed, CINAHL, the Sociological Collection, the Psychology and Behavioral Science Collection, the National Criminal Justice Reference Service, and the Science Citation Index were searched for this

review. The keywords "assault" and "aggression" were paired with "healthcare worker," "mental health worker," "mental hospital," "mental health staff," "organizational climate," and "safety climate." The returns were examined for relevant articles and reference lists were hand-searched for additional materials.

This review begins by describing the incidents and outcomes of assault and by discussing the definition of assault. The literature on staff and patient perceptions of assault is presented, followed by mental health outcomes of assault and organizational and safety climate information.

Assault on Healthcare Workers

Kindy, Petersen, and Parkhurst (2005) conducted a qualitative, phenomenological study to "give voice" to nurses who work in environments with a high risk of assault. The researchers defined assault as physical assault and verbal threats. The purposive sample was six female nurses and four male nurses with an average age of 39 years old (range 28-52). The sample nurses had experience in psychiatric settings ranging from 2 to 17 years (μ=7.4). Most participants were associate's degree nurses (n=5), followed by bachelor's degree nurses (n=4), and one master's prepared nurse. The data were categorized into four groups of meanings. The first category, Safety Fortifications, described the two elements where nurses in potentially assaultive environments instituted safety fortification. The first element, personal preparation, included special training in communication techniques including body language and noting patterns of behavior and positioning of the body. Medication management, considering client histories and

teamwork were also forms of personal preparation. The second form of safety fortification was tangible devices such as walkie talkies, cameras, mirrors, medication, seclusion and restraint. The second category of data, catalyst for violence, had four elements including facility design, increased acuity and insufficient staff, unpredictable or uncontrollable environment, and administrative or staff abandonment. Participants complained of feeling abandoned by administration through poor staffing practices, mandatory overtime, avoidance of the patient care area, and promises that were not kept. In addition, participants claimed physicians are stated to have decreased patient medications without warrant, did not follow the patient's treatment plan, provided slow emergency response, displayed professionalism elitism, and unconcerned about patient behaviors, and showed disrespect for racial, ethnic and gender issues. Nurses also highlighted patient behavior related to the disease process, such as impulsiveness or explosiveness, as being a part of the environmental issues but the nurses felt more impacted by the lack of support from their co-workers, physicians and administrators.

The third category identified was the perplexing aftermath of the assault including blame and punishment, fear and poor morale, and vigilance and distrust. Following assault, nurses found they were sent back to the same work environments with the same risks and the same patient that assaulted them. Nurses expressed little hope for change and some stated a desire to leave their jobs. Participants expressed fear of future injury and the possibility of being unable to work. The final category is pervasive invasive sequelae including conflicting feelings about the elements of their nursing career that

bring gratification and the actual day-to-day practice. Participants described feeling shut down and withdrawn so clients would not sense their fear or simply burning out from the overwhelming level of stress.

In a large-scale quantitative study, the Minnesota Nurses' Study randomly selected 6,300 nurses for a survey to establish the incidence and outcomes of work-related violence (Nachreiner, Gerberich, Ryan & McGovern, 2007). The study used the NIOSH definition for physical assault: "hit, slapped, kicked, pushed, choked, grabbed, sexually assaulted, or otherwise subjected to physical contact intended to injure or harm" (CDC, 2002). The survey had a 78% response rate and 475 nurses reported having at least incident of physical assault in the past 12 months. The study sample was predominantly female (96%), RNs (75%) whose average age was 46 years (SD $\pm$10.1). A control group of 1,425 nurses who did not experience assault were used to examine protective factors for assault. The assault rate was 13.2 per 100 nurses (95% CI 12.2-14.3) in the past year and 38 nurses per 100 (95% CI 37.4-40.4) reported witnessing at least one episode of threat, sexual harassment or verbal abuse during the same time period. The majority of both cases and controls agree that the supervisors expressed concern (case: 68%, control: 73%) and paid attention (case: 70%, control: 75%) to those they supervise.

The study cases were more likely than the control group to agree that all levels of hospital staff consider assault to be an expected event when performing patient care including the administrative level (case: 61%; control: 34%, $p<0.01$), the coworker level (case: 76%, control: 39%, $p=<0.01$) and at a personal level (case: 77%, control: 42%,

p=<0.01). The control group were more likely to agree that their administrator took action to correct or prevent assault (case: 46%, control: 60%, p=<0.01) while the study cases were more likely to agree that they had personally taken action to correct or prevent assault (case: 81%, control: 67%, p=<0.01) or that a coworker (case: 71%, control: 58%, p=<0.01) had taken those actions.

In another large study, the Emergency Nurses Association conducted a cross sectional survey of its 31,905 members in the United States (Gacki-Smith, Juarez, Boyett, Homeyer, Robinson, & MacLean, 2009). The 69-item survey had a response rate of 10.9%. The sample was mostly women (84.4%) and most worked in general emergency rooms (87.4%). The average years of nursing experience in the sample were 16.5 years (SD $\pm$ 10.7 years), average years working in the emergency department were 12.1 years (SD $\pm$ 8.8 years, and experience in the current emergency department was 7.6 years (SD $\pm$ 7.2 years). Twenty-three percent of the sample (n=811) was identified as having frequent physical violence experience (FPVE). The nurses in the FPVE group were more likely to be female (FPVE group: 25.2%, non-FPVE group: 74.8%, p=<0.001), work nights (FPVE group: 31.3%, non-FPVE group: 68.7%, p=0.002), work weekends (FPVE group: 27.9%, non-FPVE group: 72.1%, p=<0.001) and to feel that violence from patients and visitors was unavoidable as a part of their jobs (FPVE group: 32.2%, non-FPVE group: 67.8%, p=<0.001).

Barriers to reporting violent incidents included concern that reporting violence could affect customer service ratings (FPVE group: 31.8%, non-FPVE group: 68.2%,

p=<0.001) or that reporting incidents of violence would be perceived as incompetence (FPVE group: 33.5%, non-FPVE group: 66.5%, p=<0.002) (Gacki-Smith et al., 2009). There was a concern about retaliation for reporting violence from either the hospital administration (FPVE group: 36.4%, non-FPVE group: 56.6%, p=<0.001) or the emergency department management (FPVE group: 36.4%, non-FPVE group: 56.6%, p=<0.001). Ambiguous reporting policies (FPVE group: 30.9%, non-FPVE group: 69.1%, p=<0.001or the perception that no one reports violent incidents in the emergency department (FPVE group: 31.8%, non-FPVE group: 68.2%, p=<0.001) were also related to the experience of frequent physical assault by nurses.

Gacki-Smith et al. (2009) found that nurses in the FPVE group were more likely to perceive that violence was related to environmental factors. The FPVE group identified intoxication (FPVE group: 94.7%, non-FPVE group: 90.0%, p=<0.001), drug-seeking behavior (FPVE group: 94.0%, non-FPVE group: 89.4%, p=<0.001), and use of illicit drugs (FPVE group: 94.3%, non-FPVE group: 87.7%, p=<0.001) as being an environmental factor leading to violence more frequently than the non-FPVE group. The FPVE group was more likely to perceive patient crowding (FPVE group: 91.1%, non-FPVE group: 86.5%, p=0.001) and registered nurse shortage in the emergency department (FPVE group: 66.2%, non-FPVE group: 55.8%, p=<0.001) to be perceived as factors related to violence. Care of psychiatric patients in the emergency department (FPVE group: 91.9%, non-FPVE group: 86.7%, p=<0.001), the practice of boarding of holding patients (FPVE group: 68.3%, non-FPVE group: 56.3%, p=<0.001), and the care

of patients with dementia or Alzheimer's disease in the emergency department (FPVE group: 59.1%, non-FPVE group: 53.8%, p=0.009) were perceived as a precipitator of violence more often by the FPVE group. Lastly, FPVE nurses were more likely to agree that communication issues in the emergency department contribute to physical violence including: misperceptions by patients or visitors that staff is uncaring (FPVE group: 71.8%, non-FPVE group: 64.6%, p=0.001) or misconception of staff behavior (FPVE group: 69.7%, non-FPVE group: 65.9%, p=0.048).

Assault in Mental Health Hospitals: Incidence and Outcomes

Flannery, Hanson, and Penk (1995), researchers with a well-established body of research in assault, suggest that the commonly accepted definition of assaults as unwanted physical or sexual acts should be expanded to include threats intended to harm specific staff, either verbal or non-verbal. The recommendation is based on the study by Flannery et al. (1995) that described violent incidents toward staff in a 400-bed state mental hospital. The staff included 391 males and 367 females. Most staff members were mental health technicians (n=290) and administrative personnel (n=283). Other staff included registered nurses (n=106), clinicians (n=60), and licensed practical nurses (n=19). All staff, including administration, were trained and asked to report on one episode of violence per patient to prevent reporting of multiple acts of violence on a single patient. Three hundred and seventy episodes of patient violence were reported including: physical and sexual assault (n=82), verbal threats (n=143), non-verbal threats (n=25), physical or sexual abuse with verbal threats (n=74), physical or sexual abuse with

non-verbal threats (n=19), and episodes of verbal and non-verbal threats combined (n=10). Both males and females who were threatened had mental health effects similar to victims who were physically assaulted, with some threat victims developing post-traumatic stress disorder-like symptoms, difficulty with mastery and meaning of the event, or disturbances more than a week after the event. Despite the compelling case to include verbal threats as a part of the definition, there is no consensus on a definition for assault in the literature.

In a comprehensive 135-question survey of nurses and psychiatrists working in eight outpatient psychiatric centers in the United Kingdom, Soares, Lawoko, and Nolan (2000) reported 85% of staff (n=1051, 69% response rate) were assaulted at least once in their career and 57% of staff surveyed were assaulted in the past year. Those who had been assaulted in the past year had different perceptions of the work environment from those who had not been assaulted. Those who were assaulted in the past year were significantly more likely to be young (χ_2 =34, $d.f.$=4, p<.01). Among those participants under 30 years of age, 93% reported an assault episode in the past year compared with 72% of participants aged 30 to 39, 59% aged 40 to 49, 60% aged 50 to 59, and 42% of those participants aged 60 and over. Increases in violence were reported among workers with less experience (χ_2=27, $d.f.$=3, p<.001) and less supervision (χ_2=11, $d.f.$=3, p<.001) and those in noisy work environments (χ_2=28, $d.f.$=3, p<.001), in areas with poor lighting (χ_2=23, $d.f.$=3, p<.001) or ventilation (χ_2=26, $d.f.$=3, p<.001), and in workplaces where staff felt little autonomy (χ_2=24, $d.f.$=3, p<.001) or influence over planning their work

(χ_2=8, *d.f.*=3, p<.05). The survey also found that workplaces with little organizational pride (χ_2=9, *d.f.*=1, p<.005), poorly defined goals (χ_2=13, *d.f.*=4, p<.05), or lack of social support (χ_2=4, *d.f.*=1, p<.05) had increased violence.

Much of the published literature on assault in mental health facilities is from international literature including research from Australia, Bahrain, Taiwan, and the United Kingdom. The findings in these studies are similar to those among studies done in the United States and demonstrate relevance of the problem domestically (Hamadeh, Alaiwat, & Asari, 2003; Chou, Lu, & Moa, 2002; Owen et al., 1998; Barlow, Grenyer, & Ilkiw-Lavalle, 2000; Soares et al., 2000). A cross-sectional study of assaults in Bahrain indicates a lower overall incident of assault than most studies in the United States with 4.4 assaults per 100 staff; however, assaults represented 60.4% of all injuries (Hamadeh, et al., 2003). The causes of injuries due to assault were most often from a physical blow (46.3%), wounding (29.9%), biting (17.9%), and pushing (5.9%). Hamedeh et al. also indicated that males were assaulted more often than females (odds ratio [*OR*] =2.28).

A cross-sectional survey of 79 staff nurses on seven acute psychiatric wards in Taiwan by Chou et al. (2002) found most patient aggression (55.3%) was directed oward other people rather than at objects, although assaultive behaviors are more common toward other patients (55.2%) than staff (39.2%). Staff risk factors for assault were nurses of a young age, fewer years of work experience, and lack of assault training. Patient risk factors for assault behavior were diagnosis of schizophrenia, long duration of admission, and history of smoking. Organizational factors contributing to assault were a high patient

to staff ratio (r=.22, p<.01) and a decrease of personal space for patients (r=.27, p<.01). The patient to nurse ratio ranged from 2.6 to 3.3.

Characteristics of patients who express outward violence toward staff and other patients were explored in a cross-sectional survey by Bowers, Simpson, and Alexander (2003). The investigators surveyed patient behaviors with the Patient-Staff Conflict Checklist (PCC) during the first two weeks of admission to acute admission wards in London. The PCC is a checklist of 21 conflict behaviors and eight containment measures. The sample was 238 patients comprised of mostly males (59%) who were voluntarily admitted (58%) with a mean age of 40 years ($s.d.$=13 years). The investigators found that 90% of patients had some behavior problems in the first two weeks of admission and 81% experienced at least one containment measure during that time. Patients who exhibited aggression against objects and others and attempt to leave without permission were significantly more likely to deny their mental illness, refuse medication, or disagree with a treatment plan and were more likely to assault staff.

A study of Australian workers by Barlow et al. (2000) found verbal threats, similar to Flannery et al. (1995), were the most common form of assault (22.8%) followed by physical assault (14.6%). Similar to the Bahrain study, assault accounted for 47.4% of all injuries, the largest single injury type. Barlow found a small percentage of patients (40.2%) were responsible for most of the violence (71.0%). Patient factors contributing to violence were a diagnosis of schizophrenia, involuntary admission, and crowding.

McKinnon and Cross (2008) conducted a descriptive study of 63 Australian nurses who worked in two adult psychiatric inpatient units and on community-based teams. The investigators developed a 16-item questionnaire based on prior research with the addition of new questions. Validity was assessed by a panel of nursing experts prior to implementation of the survey instrument. The sample was mostly female (68.3%) and evenly divided between inpatient (47.6%) and community (52.4%). Ages ranged from 18 to 51 with 55.56% of the sample over 40 years of age. Experience ranged from less than one year to 11 years on the job. A significant difference was noted ($x2$=8.39, p<0.004) between male (95%) and female (53.5%) respondents and the incidence of injury resulting from occupational violence. In the year prior to the study period, 88.9% (n=56) had encountered at least one episode of occupational violence and 50.8% (n=32) had experienced violence between one and three times in the past year. The most common source of the violence was patients (88.9%); however, respondents also described violence from the patient's family members, visitors, and colleagues. The most common form of violence was verbal abuse (81%, n=51). Most of the respondents (66.7%) indicated that they had been injured at work as a result of assault. Reported injuries include: scratches (23.8%, n=15), cuts (12.7%, n=8), abrasions (15.9%, n=10), bruises (47.6%, n=30), headaches (27.0%, n=17), sprains (17.5%, n=11), muscle tears (7.9%, n=5), a fracture (1.6%, n=1), bruising (15.9, n=10), a wound requiring sutures (1.6%, n=1), and other (31.8%, n=20).

Most respondents (85.7%, n=54) had received training on prevention of occupational assault and 81% stated that they were "somewhat" confident about managing incidents of violence while only 12.7% (n=8) felt "confident" about managing violence. Spearman's rho analysis showed no relationship between being a victim of violence in the past year and the respondent's confidence in managing violence; nonetheless, a significant positive correlation existed between the respondent's reported confidence level in managing violence and his or her satisfaction with administration's management of issues related to occupational violence (rho=0.297, p=0.018). There was no significant difference in the overall number of times the inpatient staff had been assaulted as compared to the community staff, but inpatient staff were more likely to have been assaulted within the past year (t=1.956, p=0.028).

In addition to the physical effects of assault, McKinnon and Cross (2008) described the mental health effects of this respondent group. Most respondents (84.10%, n=53) describe "sometimes" feeling fear at work, while 12.70% (n=8) described "often" feeling fear at work, and only 3.20% (n=2) described never feeling fear at work. Over three-fourths of the respondents (76.20%, n=48) described the feeling that their safety was compromised when performing their work.

Another Australian study examined the effect of staff gender on assault. Daffern, Mayer, and Martin (2006) conducted a descriptive and correlational study at an 80-bed specialty forensic mental health facility. The beds were divided into two programs for acute and chronic mental illness. The acute care program was divided into three units—

two 15-bed units for males and one 10-bed unit for females. The continuing care unit had two units: a 20-bed extended care unit and a 20-bed intensive psychosocial rehabilitation unit. Staff were asked to record all aggressive behavior using the Overt Aggression Scale, an instrument that categorizes aggressive behaviors into four groups: 1) verbal aggression, 2) physical aggression against objects, 3) physical aggression against self and, 4) physical aggression against other people. Descriptive statistics were used to describe the nature and type of aggressive behaviors. Correlational analyses were performed to examine the relationship between staff gender ratio, gender of the charge nurse, and the likelihood of aggression.

During the six-month study period, staff recorded 316 incidents of aggression. Similar to other studies, the researchers found that verbal aggression was the most common form of aggression, accounting for 62% (n=196) of reported incidents of aggression. Physical aggression against other persons followed with 29.1% (n=92) of recorded incidents and physical aggression against objects accounted for 8.9% (n=28) of recorded incidents. Aggression toward other persons was most commonly directed at staff (n=222, 70.3%) rather than other patients (n=61, 19.3%). Using a chi-square analysis to examine the correlation between acts of recorded aggression on the female acute unit and the gender of the charge nurse, 502 shifts were reviewed to identify 341 shifts with a female charge nurse, 139 shifts with a male charge nurse, and 22 shifts in which the gender of the charge nurse could not be identified. Daffern et al. (2006) found no significant difference between the number of incidents of aggressive behavior during

shifts with a female charge nurse and a male charge nurse ($\chi_2(2)=1.363$, p=not significant (NS)) and, in occurrence of aggressive behaviors and the mean percentage of female staff (t (544) =-0.220, p=NS). The severity of aggressive behavior and the percentage of male staff was not significant (Pearson Correlation=0.115, n=66, p=NS).

On the male acute wards, 1092 shifts were reviewed. There were 453 shifts in which the charge nurse was a female and 639 shifts with a male charge nurse. There was no significant difference in occurrence of aggressive behaviors between male and female charge nurses (χ_2 (1) =1.204, p=NS). No significant difference was identified for occurrence of aggressive behavior with mean percentage of male staff on the unit (t (544) =0.220, p=NS). The correlation between severity of aggressive behavior and the percentage of male staff working was not significant (p=0.2, Pearson Correlation=0.99, n=170). In the 50 occasions that a patient was secluded following an aggressive behavior, there was no significant difference (χ_2 (2) =0.335, p=NS) in gender of the charge nurse.

Similar to the findings of the Australian study, a descriptive study in Italy by Grassi et al. (2001) examined 1,534 patients over a five-year period to identify a small number of patients (n=116) responsible for most of the violent episodes (n=329). The overall prevalence of violence was low at 7.5% of the study population with staff as the most frequent victims of assault. The most common diagnoses for assaultive patients were schizophrenia and delusional syndromes (n=51, 55.1%).

A retrospective analysis of formally reported incident rates and reports was conducted by Bowers et al. (2003) to examine the relationship between the presence of

medical residents and nursing students on the unit and the occurrence of assault and to describe the distribution of incidents over time. The investigators reviewed records of adverse incidents, nursing student placement, and medical resident rotation patterns from three hospital sites. The sites had a total of 14 acute psychiatric wards and three psychiatric intensive care units. The time period reviewed was a 136-week period between 2002 and 2004. There were 546 occasions that one or more nursing students were newly placed on a unit. For a period of six weeks following new placement on the unit, there was a significant decrease in physical aggression (*IRR*=0.82, *r2*=0.004, *p*=0.14). There was no significant increase or decrease in verbal aggression, property damage, or self-harm. Similarly, there was a decrease in physical aggression following the 134 occasions of placement of new medical resident on the unit (*IRR*=0.65, *r2*=0.003, *p*=0.036). Elopements also decreased in the third week of the four-week placement (*IRR*=0.56, *r2*=0.003, *p*=0.048). There was no significant difference in the incidence of verbal aggression, property damage, or self-harm following the placement of nursing students and medical residents.

Bowers et al. (2006) examined the frequency of incidents occurring on the days when rounds are conducted to determine if unfavorable treatment decisions were a catalyst for aggressive patient behaviors. The analysis determined that adverse incidents were less likely to occur on the day of rounds (χ_2=0.352, *d.f.*=1, *p*=0.553). Specifically, each type of incident was less likely to occur as follows: elopement (χ_2=0.045, *d.f.*=1, *p*=0.832), physical aggression (χ_2=0.447, *d.f.*=1, *p*=0.504), property damage (χ_2=20.039,

d.f.=1, p=0.760), self-harm (χ_2=1.445, *d.f.*=1, p=0.229), and verbal aggression (χ_2=0.352, *d.f.*=1, p=0.553). Furthermore, adverse incidents were less likely to occur on weekends (χ_2=10.96, *d.f.*=1, p=0.001). The authors concluded that concerns about increases in adverse patient incidents during an influx of new staff or increased staff activity, such as the day of rounds, are supported by this data analysis.

To summarize regarding the incidence and outcomes of assault, the literature reports assault rates between 13.8 per 100 FTEs on formal injury reports to 245 assaults per 100 FTEs in staff surveys (Bensley et al., 1997). The most common type of assault is being hit, overexertion, falls, being kicked, being struck against an object, or being bitten (Hamadeh et al., 2003). Common injuries resulting from assault include: scratches, cuts, abrasions, bruising, headaches, sprains, and muscle tears (McKinnon & Cross, 2008). Factors leading to staff injuries include: working in isolation, working as a mental health technician, working on a geriatric unit, lacking training in the past year, implementing poor staffing patterns, and working as a registered nurse (Chou et al., 2002). Patients who assault are predominately male with voluntary admission and a mean age of 40 years. Most of these patients had behavioral problems in the first two weeks of admission and experienced at least one containment during that time (Bowers et al., 2003). During an assault, the majority of staff reports that assistance was not provided when called for, the reasons for the lack of assistance from other staff members were they were not heard, help was not available, other staff ignored them, or a patient assisted them (Bensley et al., 1997).

While healthcare systems and care of mentally ill patients may differ in other countries, many similarities exist between the two in the United States (U.S.). The international body of literature offers many additional studies on assault in mental health facilities. Bahrain reports a rate of assault substantially lower than the U.S. at 4.4 per 100 FTEs; however, assault remains the most common cause of injury to mental healthcare staff and the types of assault are the same (Hamadeh et al., 2003). Studies vary as to whether most aggression is aimed at staff or at other patients but, within occupations, all mental healthcare staff are at risk (Chou et al., 2002; Grassi et al., 2001). Similar to U.S. studies, staff risk factors for assault include: inexperience, lack of training, little autonomy, and lack of control over their work (Grassi et al., 2001; Soares et al., 2000). The prevalence of violent episodes in a healthcare worker's career was 85% to 88.9% and the majority of staff were assaulted in the past year (McKinnon & Cross, 2008; Soares et al., 2000). Patient characteristics for assault are diagnosis of schizophrenia, delusional symptoms, long duration of admission, and history of smoking (Grassi et al., 2001). A small number of patients are responsible for most of the assault incidents (Barlow et al., 2000).

Organizational factors that contribute to assault are high patient-to-staff ratios, use of seclusion and restraint, non-nursing absenteeism, and decreased privacy or personal space for patients (Grassi et al., 2001; Owen et al., 1998).

Mental Health Staff Experience of Patient Aggression

Duxbury (1999) used a qualitative, phenomenological design to examine nurses' experiences of patient aggression. The sample was 34 mental health nurses and 32 general health nurses. Both nurses in mental health settings and general hospital settings had similar assault accounts of verbal threats and physical assaults. Fifty percent of nurses in both groups attributed patient aggression to a diagnosis, such as a psychotic disorder. Mental health nurses were more likely to take responsibility for managing aggression by seclusion, restraint, or sedation while general hospital nurses indicated a need to involve the medical team. Duxbury asserts that "overcontrol" is being used to manage aggressive patients, with two-thirds of mental health nurse respondents (21/32) using restraint and one-third (9/32) using sedation.

Mental Health Effects of Assault on Mental Health Staff

In addition to the physical impact of violence, researchers also describe the mental health effects of assault including job dissatisfaction, burnout, and post-traumatic stress disorder (PTSD) (Richter & Berger, 2006; Whittington, 2002; Wykes & Whittington, 1998). Whittington (2002) conducted a cross-sectional survey to examine levels of tolerance and burnout using the Tolerance Scale and the Maslach Burnout Scale in a population of 37 staff members working in a specialty psychiatric hospital. While the researchers did not find a significant difference in tolerance between the assaulted and un-assaulted groups of employees, a significant difference was noted in tolerance among employees with 15 years or more of experience compared with staff who had less than 15

years of experience (t=2.94, $d.f.$=31, p<.01). Pearson's r was used to find a negative correlation between tolerance and emotional exhaustion (r=-0.34, p <.05) and depersonalization (r=-0.42, p <.05). Personal accomplishment correlated positively with tolerance (r=0.56, p<.01). Staff who expressed high levels of toleration toward patient aggression were less likely to report burnout and have more years of experience.

The most serious mental health effect described in the literature is post-traumatic stress disorder (PTSD). The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) (2002) describes the criteria for PTSD as the history of exposure to a traumatic event that causes functional difficulties in social or occupational situations and symptoms of intrusive recollection, avoidance behavior or numbing, and hyperarousal that lasts at least 30 days (American Psychiatric Association, 2002). Wykes and Whittington (1998) conducted a prospective study on three groups of nurses from six acute psychiatric wards in London to assess the nurses' responses to assault. The assessments included a number of measures of distress including: the State Trait Anxiety Inventory (STAI), the State Trait Anger Expression Inventory (STAXI), General Health Questionnaire (GHQ-28), and the Beck Depression Inventory (BDI). A group of nurses who had not been assaulted in the past month was recruited at the beginning of the study to serve as a baseline group. Another group of nurses was assessed within 10 days of the assault and again at one month. Some nurses in the first group were also included in the second group (n=10). The final group of nurses was selected concurrently with the assault group to be used as a control group. Nurses in the control

group were selected only if they had not been assaulted in the prior six months. The study lasted approximately six months until the necessary number of participants had been addressed.

Participants in the post-assault group experienced less anger control and greater incidence of PTSD-like symptoms following assault incidents. Two nurses (5%) in the assault group developed clinical PTSD 30 days or more after the assault. Additionally, the researchers found that the severity of psychological symptoms increased with the severity of injuries from the assault.

Richter and Berger (2006) examined the incidence of post-traumatic stress disorder in staff members of a mental health hospital following assaults by patients. The prospective study reported assaults in nine state mental health institutions in North Rhine-Westphalia, Germany over a six-month period. Forty-six assaulted staff members agreed to participate in the study. The mean age of the participants was 38 years of age. The gender of the population was evenly split, with 23 female and 23 male participants. Most were nurses (70%), although other participants were included, such as physicians, social workers, and housekeeping staff. Average length of time on the job was 13 years. After the assault event, 28 participants had minor injuries such as cuts and bruises, seven had severe injuries such as fractures and loss of consciousness, and 11 suffered no physical injuries.

A baseline evaluation for PTSD was done on each participant using the German version of the Impact of Event Scale-Revised (IES-R) and the German version of the

Post-traumatic Stress Disorder Checklist-Civilian (PCL-C). The baseline assessment occurred an average of 49 days following the reported assault. Richter and Berger (2006) found that 17% (n=8) of participants had PTSD symptoms at baseline. Significant differences exist between the severity level of the injury and scores on the IES-R instrument (*ANOVA:* F=8.5, $d.f.$=2, p=0.001). Participants with the most severe injuries were the most likely to score high on the IES-R (M=64.1, SD=13.5). Those without physical injuries scored higher on the IES-R instrument (M= 48.0, SD=16.3) than those with minor physical injury (M=38.3, SD=14.7). A comparison of work absence between study participants and non-participants was conducted. Non-participants missed a total of 26.6 days between the incident and baseline interview while participants reported 7.6 total days of missed work (t=-2.466, $d.f.$=44, p=0.018). During the follow-up interviews, 11 participants declined all or part of the follow-up interview. Data from these participants were excluded from the follow-up results. At the two-month follow-up, the number of participants with a diagnosis of PTSD had decreased to six participants and then three participants by the final assessment at six months.

A qualitative study by Currid (2008) examined the lived experience and meaning of stress in acute mental health nurses. The investigator interviewed a cohort of eight mental health nurses in a London mental health facility. Two subjects per unit were randomly chosen from a pool of 22 potential subjects who had voluntarily agreed to be interviewed. Themes were identified in the discussion of working conditions including: chaotic environments, constant and competing demands, and violence and aggression.

The conditions were connected to themes about staffing resources, management style, and a lack of other resources such as time or bed availability. Participants described difficulty coping when they were unable to meet the role expectations from management and meet their own standard of care for patients. This situation caused subjects to question their value in benefiting patients and to express feelings of distress centered on self-worth. Subjects described a sense of being overwhelmed by the working conditions. When discussing the stressor of violence and aggression, some participants described the feeling that management did not take patient violence and aggression seriously and felt that additional staffing to attend to patients' needs and problem behaviors could reduce the incidence of violence. In an exploration of perceived value, the nurses expressed that administrative support was less available than in other disciplines. Negative outcomes described from a lack of support included an inability to "turn off" at the end of a shift for fear they had forgotten to communicate some detail and concern that they would be blamed for if an adverse event were to occur. Currid (2008) concluded that an urgent need exists for addressing adverse events in the acute mental health setting.

Assaulted staff experience mental health effects ranging from symptoms of PTSD to perceived risk of assault, staff burnout, and an intention to leave their jobs. Staff who was more tolerant of patient behaviors had greater experience, less emotional exhaustion, less depersonalization, greater personal accomplishments, and less burnout (Flannery et al., 1995; Whittington, 2002; Wykes & Whittington, 1998).

Staff Perceptions of Assault

The problem of assaults in mental health facilities has led investigators to explore the issue from the perspective of the assaulted mental health personnel (Cunningham et al., 2003; Rossberg & Friis, 2003). Some publications focus solely on nurses as assault victims (Duxbury, 1999; Poster & Ryan, 1994). Others have taken the interesting approach of interviewing patients for their perspective on assault incidence (Bensley et al., 1995; Duxbury, 1999; Duxbury & Whittington, 2005; Ilkiw-Lavalle & Grenyer, 2003).

A study by Rossberg and Friis (2003) examines staff's reactions to aggression and suicidal behaviors. A cross-sectional survey on staff feelings was completed on 2,473 patient encounters by 253 participants. The survey results indicate that staff is more likely to express negative feelings about patients who were aggressive than those who were suicidal. Additionally, staff reported feeling anxious about, rejected by, or confused by aggressive patients. For aggressive male patients, staff expressed feelings of being on guard or feeling inadequate unlike how they felt with aggressive female patients where they expressed feelings of being overwhelmed. Staff also stated feelings of being rejected or inadequate more often when patients were 40 years of age or older.

A classic study by Poster and Ryan (1994) replicated a cross-sectional survey previously done in the 1980s. The study was replicated at five sites and added to the original database to form a total sample of 557 nurses. The study population was mostly registered nurses (77%) but also included a wide range of mental healthcare professionals

including practitioners, technicians, and physician's assistants. The response rates among nursing staff ranged from 70% to 97% (M=87%). The instrument was the Attitudes Toward Patient Physical Assault Questionnaire, which measures beliefs and concerns about assault, including safety concerns, staff performance, and legal issues. Over 65% of staff expressed the belief that assault is a part of their jobs. However, most of the staff surveyed (71%) stated they felt safe in their work environments. Newer staff was less likely to believe that staffing patterns and environmental controls are adequate to prevent assaults. Many staff members (53%) expressed concern that the institution admitted patients who could not be treated safely. Staff supported the right to take legal action against an assaultive patient and 65% stated that psychiatric patients are responsible for their actions.

Across studies measuring staff perceptions of assault, high rates of both verbal and physical assault were reported (Cunningham et al., 2003). Staff self-reported that those most likely to be assaulted are those in direct care positions, younger staff, those with less experience, and staff who earn lower pay. There was no perceived difference in likelihood of assault between male and female patients; however, staff did feel that children are more likely to assault than adults. The literature supports that staff attribute patient aggression to patients' diagnoses and many informants report that assault is a "part of the job" (Duxbury, 1999; Poster & Ryan, 1994).

Ilkiw-Lavalle and Grenyer (2003) examined patient and staff perceptions of assault. The phenomenological design examined 47 incidents of assault and found

differences in staff and patient views of aggression. Causal factors of violence were identified as state of illness, conflict, and limit setting. Patients were more likely than staff to identify interpersonal conflict as a cause of aggression. Of 29 patients in the study, 36% (n=16) found interpersonal conflicts to be a problem including: being provoked by another patient (n=9, 20%), staff not listening to the patient (n=3, 7%), patient being provoked by staff (n=2, 4%), and family conflicts (n=2, 4%). Of the 29 staff members surveyed, the likely cause of aggression was attributed to the patient's state of illness including the level of acuity on admission (n=15, 33%) and insufficient medication (n=2, 4%). Both patients (n=14, 31%) and staff (n=12, 26%) agreed that limit setting could be a cause of aggression. For control of violence, staff recommended improved medical management whereas patients suggested measures to decrease interpersonal conflict.

Duxbury and Whittington (2005) used a cross-sectional survey of staff and patients to explain causes and management of patient aggression. Similar to the Ilkiw-Lavalle and Grenyer (2003) study, patients in the survey attributed violence to communication issues with staff and environmental issues an external model. Staff implicated the internal issues such as the patient's disease state as the cause of aggression but also endorsed the external model of environmental factors.

In summary of these studies, patients and staff view assault similarly in that aggression is attributed to the state of illness and to interpersonal conflict; however, patients are more likely to cite limit setting as an issue where nurses identify insufficient

medication as a cause (Duxbury & Whittington, 2005; Ilkiw-Lavalle & Grenyer, 2003). Interestingly, both patients and staff are able to describe the events during the assault accurately but each describes themselves more positively than the other (Lanza & Kayne, 1995).

Organizational/Safety Climate in Mental Health and Other Settings

The studies discussed thus far have indicated a number of organizational issues as determinants of assault although these findings were not labeled as such. In a case study by Crow, Hartman, and Schlieder (2002), the researchers define organizational culture as "the shared beliefs, values, norms, expectations, and assumptions that are manifest in behavior and that bind people to organizations" (p. 22). While this is a very global description of how organizations "feel" to those who work within the organization, there is a sub-scale to organizational climate called safety climate.

In a classic study on safety climate, Zohar (1980) defined safety climate as the perceptions of workers regarding the importance of safety in their place of employment. Zohar and Luria (2004) studied safety climate in a large sample (n=2,024) of soldiers in Israel using a 25-item cross-sectional survey. The researchers used hierarchical multiple regression analysis models to examine supervisory patterns and leadership as predictors of safety climate. The survey (n=42) indicates that scripted leadership (β=.58, p<.001, $\Delta R2$=0.19) and orientation to the supervisory pattern (β=.24, p<.001, $\Delta R2$=.08) were consistent with better safety climate ($R2$=.41, p<.001).

Dejoy et al. (2004) examined safety climate in a population of 2,208 warehouse retail workers with a cross-sectional survey including the National Institute for Occupational Health and Safety (NIOSH) Safety Climate Scale developed in part by Dejoy. Three factors accounted for 55% of the variance in safety climate: 1) environmental conditions, 2) safety policies and programs, and 3) overall organizational climate. The author asserts that clear safety policies implemented at the organizational level are associated with improved safety performance. Dejoy et al. (2004) found communication to be an important factor in safety climate, especially when combined with social support. Furthermore, positive safety climate is likely to be present in an organizational culture that supports and values its employees.

Calabro and Baraniuk (2003) used a cross-sectional survey (n=137) to investigate safety climate in a psychiatric hospital. Safety climate was assessed as high given the number of injuries reported. Data were analyzed with multiple linear regression and three variables had significant association to safety climate, including administrative controls (PE=.555, SE=.065, t=8.600, p<.001), occupational stress (PE=.188, SE=.051, t=3.704, p<.001), and job task demands (PE=.268, SE=.080, t=3.369, p<.001).

Thomas, Sexton, Neilands, Frankel, and Helmreich (2005) explored the effect of executive walk rounds (ERW) using a randomized clinical trial. Nurses on the intervention team participated in ERW once a month for three months. The authors hypothesized a spill-over effect where nurses participating in rounds would promulgate an improved safety climate on their unit among those who did not participate in rounds.

Improved safety climate was noted only among the nurses who actually participated in the rounds. No effect was noted on the intervention units in staff who did not attend the rounds.

An assessment of safety climate demonstrated an association between administrative controls, such as policies and procedures or staffing patterns, occupational stress, and job task demands (Calabro & Baraniuk, 2003). Thomas et al. (2005) noted that safety climate is enhanced for nurses involved in the process of surveying the environment suggesting that inclusion in safety processes may positively alter staff perceptions.

Gaps in the Literature

The evidence linking safety climate and assault is weak. Descriptive studies identify determinants of assault indicating several opportunities for organizational intervention; however, these determinants have not been grouped and studied with organizational issues as a construct of safety climate. Overall, the safety climate literature strongly supports the workers' perceptions of organizational support in safety-related performance but the use of safety climate to address assault is lacking. A qualitative study examining assaulted workers' perceptions of organizational support with respect to assault could contribute to the body of knowledge on the subject.

Summary

Assault is the most common cause of injury in mental healthcare settings. The career prevalence of assault is a staggering 85% for mental healthcare professionals. Annual assaults per 100 FTEs range from 4.4 to 245, depending on the source of the data.

The actual assault is a result of being hit, kicked, bit, and thrown against an object, or falling or overexertion during the assault. In addition to the physical effects of the assault, substantial mental health morbidity results from assault, including job dissatisfaction, fear of additional assault events, and, in some cases, PTSD. Across these studies, both staff and patients have identified causal factors. One study that examined these factors specifically in the mental health setting verified that these causal factors relate to safety climate of mental healthcare staff (Calabro & Baraniuk, 2003). These include administrative controls such as policies and procedures, staffing, occupational stress, and job task demands.

The problem of assault has been well described in research both nationally and internationally. While other countries have initiated public policy related to assault, such as the United Kingdom's policy to discontinue healthcare benefits related to assault, the United States has yet to implement such a policy. Much of the research on the topic is descriptive in nature and characterizes assault and outcomes. This research, however, examined the perceptions of inpatient psychiatric staff and administrators regarding the institutional effectiveness of policies in place to prevent and manage assault. This

approach differed from the literature in that it views a component of safety climate within the context of a specific assault experience.

CHAPTER III

PROCEDURE FOR DATA COLLECTION AND TREATMENT OF DATA

The aim of this descriptive interpretive research was to examine a clinically relevant issue: patient-on-staff assault. An interpretive description design was used to examine the perceptions of inpatient psychiatric personnel and administrators responsible for ensuring a safe workplace and implementing institutional policies related to assault. Descriptive interpretation is a qualitative technique that extends beyond mere description and into the meaningful interpretation of clinical events: an account of what the subject perceives (St. George, 2010). This design was chosen for the study to meet a practice goal of reducing and preventing injuries and to develop what is known and unknown based on available empirical evidence (Thorne 2008). This qualitative approach allowed for the evaluation of administrative controls put in place by institutions to prevent, address and monitor assault among in-patient psychiatric personnel. The more flexible approach of a qualitative design allowed for individuals to express their perspectives on the administrative controls that would not be identified in a more linear quantitative design (Polit, Beck, & Hungler, 2001).

Holstein and Gubrium (2005) described a reciprocity of interpretive description and social reality. When using interpretive description as applied to a practice issue, both the "hows and whats" of social reality are engaged. The method is centered on how people construct their experiences and their world and what meaning is derived to inform

their reality and practice activities. The sections that follow describe the setting, sample, protection of human subjects, instruments, data collection procedures and treatment of the data for the study.

Setting

The setting for the study was Harris County, Texas, with a population of over four million residents (United States Census Bureau, 2003). A well-developed system of both public and private mental health agencies serve the estimated 30,000 residents of Harris County with mental illness or mental retardation, including homeless outreach, mobile units, crisis centers, ambulatory care, and inpatient services (Mental Health Mental Retardation Authority of Harris County (MHMRA, 2012).

Harris County has 825 inpatient psychiatric beds in multiple institutions throughout the 1,700 square mile county (MHMRA, 2012). Inpatient psychiatric care is available in general hospitals that have the ability to manage both physical health and mental health needs by providing skilled nursing care and a full complement of specialty healthcare. Stand-alone specialty psychiatric hospitals treat patients with acute psychiatric illness and chemical dependency but who are medically stable. Patients in mental health crisis requiring assessment and intervention can use the Neuropsychiatric Center (NPC), a public mental health emergency room open 24 hours a day/7 days a week. Over 10,000 adults and children, primarily uninsured or underinsured, are provided care by the NPC annually (MHMRA, 2012).

Sample

A purposive sampling was used to recruit staff and administrators who work at inpatient psychiatric centers into the study. This method supported selection of participants who have had first-hand experiences with assault either as the person being assaulted or as an administrator who participates in institutional planning to prevent and manage assault. A snowball technique was used in which the researcher identified people who knew other people who might have an information rich event that could be relevant to the study (Polit, Beck & Hungler, 2001). In addition, the sample was stratified by inpatient psychiatric personnel who have experienced workplace assault during the past 12 months and administrators of inpatient psychiatric centers. The researcher may adjust the composition of the study to assure a rich description of the events by including a diverse sampling within the two groups.

Sample size was planned to be approximately 20 participants, however, it was deemed complete at 14 subjects after a thick description of the processes and policies had been obtained. Sample sizes in qualitative studies are smaller than quantitative studies because the outcomes of the research are different and statistical analysis is not performed (Burns & Grove, 1993). The sample size was determined by the outcomes of the descriptive interviews and the saturation of the concepts within the data. Saturation was reached when no additional new information or concepts emergeed and the data became redundant and confirmed data previously collected (Polit, Beck & Hungler, 2001,

Speziale & Carpenter, 2003). The researcher recruited subjects until saturation of data has occurred.

The subjects were English-speaking psychiatric personnel who worked in inpatient facilities in Harris County. Professions of direct patient care providers included nurses and psychiatric technicians. A second group of subjects, administrators, included leader who were charge nurses, nursing administrators, and quality leaders. Participants were interviewed to give a description of a workplace assault from the perspective of either a direct care provider or an administrator. The sample size was seven subjects in each group.

Protection of Human Subjects

The research received approval from the Texas Woman's University Human Subject Review Committee (Appendix A) prior to beginning research. Interviews were be conducted privately in a conference room or mutually agreed upon location. The interviews lasted approximately 45 to 60 minutes and written informed consent was obtained prior to data collection (Appendix B). At that time, participants were informed of the ability to withdraw from the study at any time. Participants were also informed of potential risks and benefits to participation and the treatment of data intended to protect confidentiality. Risks to participants included the possibility of anxiety or stress related to discussions of an assault experience or loss of confidentiality. There were no direct benefits to participants in the study; however, outcomes of the study may shape future programs and policies intended to prevent assault. Subjects were also advised that the

interview would be digitally recorded and transcribed. The researcher contacted two participants following the interview to check for clarity and meaning in the transcribed document.

All interview recordings were transcribed and coded; names were removed. The field notes, recorded interviews and other information specifically relating to the participants were stored in a locked cabinet in the principle investigator's office. These documents will be destroyed at the end of the study by computer deletion or shredding, as appropriate.

Instruments

Instruments used to collect data in this study included a demographic questionnaire, structured questions, and prompt questions to clarify and gain additional details and descriptions. The demographic questionnaire was completed by each subject and recorded on a written tool (Appendix C). Information gathered included: age, educational level, gender, current role, number of years in their current role, number of total years in their role, and frequency of assault. These variables were chosen because the literature commonly reports significant differences in measurements based on gender, education, role and experience. Organizational variables including size and type of facility were gathered. The information shared on this tool were used to describe the sample.

Interviews of subjects followed the study question guide which was composed of structured questions and prompt questions to guide the interview (Appendix D). The

interview questions were aimed at gathering data from the individuals closest to the event who could explain the precursors and outcomes of the assault from a first-hand perspective. The administrators were those accountable for maintaining an environment safe for patients and staff and who apply the organizational policies, procedures and processes related to assault on a daily basis. Inpatient psychiatric workers were asked to describe their most recent assault experience, either as inpatient psychiatric personnel or administrators, to identify the precipitating factors, how the assault event was resolved, the reporting process, and the expectations for administration. Administrators were asked similar questions from the context of managing assaults.

Data Collection

Following approval from the Texas Woman's University Institutional Review Board (IRB), semi-structured interviews were conducted with individual mental healthcare workers who had experienced an assault by a patient resulting in injury to the worker. Participants were identified and asked into the study by networking with psychiatric professionals and professional organizations. Interviews were conducted in person at a private location mutually agreed upon by the researcher and the subject. The semi-structured interview technique assured that all questions were covered in the interview (Polit, Beck & Hungler, 2001). The strength of this approach to data collection included a high response rate to questions, as compared with a written survey, and the ability to clarify understanding and probe for additional information. Data were digitally recorded, transcribed, and then reviewed for accuracy and completeness. Data collection

continued until direct care staff and administrator interviews had developed a rich description of assault, and no new data was emerging from the interviews.

Study participants who completed the interview were offered a $20.00 gift card. The offer of money was intended to be an expression of gratitude for the time and effort the participant spent to contribute to the research.

Data Analysis

The interpretive descriptive design encourages the researcher to use the traditional methodological guidelines as a conceptual guide rather than as a rulebook. The researcher used the data analysis method of interpretation described by Giorgi (1970). The first step was to read the participant's entire description for an overall impression followed by another review to identify what Giorgi calls, "meaningful units". That is, the identification of a distinct block or units that have a self-contained meaning. The units were divided by using key words, attitudes or values that were expressed in the description. Giorgi emphasized that the identification of meaningful units is a tool to aid in a detailed analysis of the content but these units must be considered in context to be meaningful (Polit, Beck & Hungler, 2001).

The next step in data analysis was to transform of the data into a "psychological language", a two-step process. The first step required the researcher to restate the meaningful unit into her own words as simply as possible. The next step was to review the meaningful units within the context of the study purpose.

The final step of the data analysis was the synthesis and integration of the transformed meaning units from each description into a final consistent description of the concept under study (Giorgi, 1985; Polkinghorne, 1989). There were two levels to this step, developing a situated structure and a general structure. The situated structure, or specific description, is a descriptive statement of the characteristics of each subject. After completion of the situated description for each subject's description, the researcher made a general structure, or general description, for each subject's description. The researcher thus gathered the most general and essential meaning.

Giorgi's third step uses an essential concept from Husserl's phenomenology, imaginative variation. The researcher used imaginative variation to follow the concrete experience of the subject and reflect about the meaning of the experience. The purpose in this step was to make a meaning transformation that allowed for consistent inter-subjective agreement (Giorgi, 1985; Polkinghorne, 1989).

The fourth step of the data analysis was the synthesis and integration of the transformed meaning units from each subject's description into a final consistent description of the concept under study (Giorgi, 1985; Polkinghorne, 1989). There were two levels to this step, developing a situated structure and a general structure. The situated description, or specific description, was a descriptive statement of the characteristics of each subject. After completion of the situated description for each subject's description, the researcher made a general structure, or general description for each subject's description. The researcher gathered the most general and essential

meaning. The general structure focused on the aspects of the study that transcended a specific situation to have universal validity.

The final step of Giorgi's data analysis was to create a general structure of the concept under study (Giorgi, 1985). The researcher did a final general analysis to synthesize and integrate the meaningful units from each subject's description to develop a final description of the commonalities of all the subjects' descriptions. The researcher then focused on the essential aspects and characteristics of the study's purpose to developed a universal description.

Scientific rigor was addressed with consideration of the four criteria of trustworthiness: credibility, dependability, confirmability, and transferability (Polit, Beck & Hungler, 2001). Assurance of credibility involved prolonged engagement or an investment of sufficient time in the data collection activities to have a well-developed and thorough understanding view of the participants (Polit, Beck & Hungler, 2001). Credible data also involved persistent observation, a special focus on aspects of the interview that were relevant to the phenomenon under study. Dependability was confirmed by an inquiry audit by the researcher's committee chair. The audit involved scrutiny of the transcribed interviews produced as a result of the inquiry (Polit, Beck & Hungler, 2001). Confirmability, or the objectivity or neutrality of the data was accomplished by establishing audit trails of raw data and noting thoughts, impressions, and decisions made in the course of the research (Polit, Beck & Hungler, 2001). Transferability, the extent that data can be transferred to other settings or groups, was accomplished by providing a

thick description of the setting, the participants, and the processes followed during the inquiry. The thick description allowed a person contemplating a transfer of the findings to determine whether a transfer is a possibility (Polit, Beck & Hungler, 2001).

Pilot Study

A pilot study was designed using a phenomenological design to examine the events and administrative processes related to patient-on-staff assaults in a specialty psychiatric hospital. The study was conducted in the fall of 2006 and was approved through the UTHSCH Committee for the Protection of Human Subjects and the Texas Woman's University Human Subject Review Committee. A pilot population of three participants was asked to describe a recent patient-on-staff assault from the point where they knew the patient was going to become physically violent. All of the participants admitted to multiple assault episodes in their career but were asked to specifically focus on the most recent assault episode that resulted in injury and the need for medical care. Each participant described similar processes to managing assaults including gathering support to avoid a physical altercation and the intervention to halt the physical assault. Participants spoke positively about support from supervisors and the organization, but were critical of staffing, security, and the admissions process. The participants also criticized organizational policies as being too aggressive in managing verbal aggression. Participants reported mixed feelings about the effectiveness of the non-violent crisis intervention training.

Since the time of the pilot study, the study's theory and questions were changed to align more closely with the study's purpose. The questions and prompts used to explore the research questions gather meaningful responses from the participants; however some changes focused the data more closely on the participant perceptions regarding institutional policies in place to prevent, address, and monitor assault. The addition of administrators to the sample offered a different perspective of the problem of assault. Recruiting participants through a networked sample rather than a flyer improved recruitment.

CHAPTER IV

ANALYSIS OF DATA

The purpose of this interpretive descriptive study was to explore and describe how inpatient psychiatric personnel and administrators who work at inpatient psychiatric facilities perceive institutional policies in place to prevent, address, and monitor assault. Semi-structured interviews were conducted and digitally recorded using a purposive sample of inpatient psychiatric personnel who had been assaulted in the past year and administrative personnel who were responsible for maintaining a safe environment. These data describe the structure and essence of participant perceptions as derived through intensive study of individual cases (Thorne, 2008). This chapter provides a description of the sample and the findings of the study.

Research Questions

The research questions addressed in this study were:

1. What are the perceptions of inpatient psychiatric personnel regarding institutional policies in place to prevent, address, and monitor assault?
2. What are the perceptions of administrators regarding institutional policies in place to prevent, address, and monitor assault?

Description of the Sample

The participants were recruited with a networked sample in which inpatient

psychiatric personnel, administrators, and others with connections to potential participants referred others to the study. Private interviews were conducted to explore the research questions. Subject recruitment continued until a thick description of the policies and processes had been obtained. Results from the demographic questionnaire and the interviews are presented below. In addition to interviews, policies and procedures related to patient-on-staff assault were obtained from five psychiatric specialty care institutions.

Setting

The setting was four hospitals located in Harris County, Texas: three psychiatric specialty hospitals and one general hospital with a psychiatric care unit. The number of psychiatric beds at each institution ranged from 15 to 250 beds (M = 195.50, SD = 92.18). The Health Care Financing Administration (HCFA) has classified three of the hospitals as inpatient, acute care and one facility was classified as inpatient, non-acute.

Demographic Information

The average age of all participants was 49.07 years (SD = 10.26). Participants ranged in age from 35 to 65 years. The majority (71%) of participants were female. The length of time in their current occupational role ranged from 2 years to 26 years (M = 12.38, SD = 7.20). Experience in psychiatric health care specialty ranged from four months to 30 years (M = 20.88, SD = 9.64). The participants had been with their current employers between 2 months and 26 years (M = 12.51, SD = 8.90). The majority of the sample were RNs (n = 11, 79%) and the remaining subjects were psychiatric technicians (n = 3, 21%).

All participants had been trained in non-violence crisis intervention within the past 12 months with the exception of a certified trainer who is credentialed every two years. Seven participants had additional training related to violence prevention from nurses' continuing education and other professional sources. All participants (100%) had been assaulted in their career and the number of assaults ranged 1 to 40 assaults ($M = 1.07$, $SD = 1.16$). Eight participants had experienced an assaulted within the past 12 months with a range of two to four assaults ($M = 5.50$, $SD = 9.75$).

Participants in administrative roles were all female between the ages of 49 and 65 years ($M = 55.71$, $SD = 5.28$) of age. The length of time in psychiatric specialty care ranged from 14 to 30 years ($M = 24.29$, $SD = 4.56$) of experience. The participants had worked with their current employer between 14 and 25 years ($M = 15.28$, $SD = 8.03$) and the length of time in the current role ranged from 4 to 26 years ($M = 14.43$, $SD = 6.46$). Four of the six administrators had participated in training in addition to the routine nonviolent crisis intervention. The prevalence of assault events during their career ranged from one to five assaults ($M = 2.29$, $SD = 12.96$) and one of the administrators had experienced two assaults ($M = 0.29$, $SD = 0.70$) in the past year.

Inpatient psychiatric personnel in direct care roles ranged in age between 28 and 60 years ($M = 55.71$, $SD = 9.72$). The length of time in psychiatric specialty care for the direct care population ranged from five and 30 years ($M = 24.29$, $SD = 11.90$) and the range of years in the current role ranged from four months to 18 years ($M = 14.43$, $SD = 7.32$). Length of time with the current employer ranged from two months to 25 years (M

= 15.28, *SD* = 8.86). One direct care participant had completed a continuing education program on violence prevention for nursing continuing education. The prevalence of assault in their career ranged from one to 40 assaults (*M* = 8.71, *SD* = 12.96) and the direct care participants had experienced a range of one to four assaults (*M* = 1.86, *SD* = 1.06) in the past year.

Table 4.1

Descriptive Statistics for Demographic Variables

	Direct Care Providers N(%)	Administrators N(%)	Total N(%)
Gender			
Male	4(57%)	0(0%)	4(29%)
Female	3(43%)	7(100%)	10(71%)
Age			
≤ 35 years	2(29%)	0(0%)	2(14%)
>35 years	5(71%)	7(100%)	12(86%)
Years experience in Psychiatric Mental Health			
≤ 10 years	3(43%)	0(0%)	3(21%)
>10 years	4(57%)	7(100%)	11(79%)
Years with current employer			
≤ 10 years	5(71%)	2(29%)	7(50%)
>10 years	2(29%)	5(71%)	7(50%)
Work Setting			
Inpatient – acute	6(86%)	6(86%)	12(86%)
Inpatient – non-acute	1(14%)	1(14%)	2(14%)
Training on nonviolent crisis intervention			
Within past 12 months	6(86%)	7(100%)	13(93%)
Greater than 12 months	1(14%)	0(0%)	1(7%)
Additional training on nonviolent crisis intervention	2(29%)	5(57%)	7(50%)
Assault experience			
Event within past 12 months	7(100%)	1(14%)	8(57%)
Event within career	7(100%)	7(100%)	14(100%)

Name of Participants

The actual names of the 14 participants were protected in accordance with the design of the study and standard qualitative research guidelines (Creswell, 1998). The researcher randomly selected twenty pseudonyms with four letter names, ranging from the letter A to the letter Z. The names assigned to the direct care providers were Dyan, Gabe, Kala, Levi, Nita, Otis, and Seth. Names assigned to administrators were Bree, Erin, Hope, Jodi, Nell, Rene, and Vera. Genders of names were assigned according to respondent's gender. Assigned pseudonyms were used in results of the analysis to highlight which respondent made which statement relevant to themes and subthemes.

Findings

The researcher's objective was to identify factors relevant to the research questions through a qualitative design based on interpretive description. This descriptive methodology is applicable to developing solutions for practice issues within the clinical environment (Thorne, 2008). A networked sample of 14 subjects was recruited to explore the research questions, as well as the sub-questions. Each interview was considered individually and collectively according to the data analysis method of interpretation described by Giorgi (1970). Common themes were identified across data with regards to addressing the research questions. Findings were compared to representative policies gathered from the inpatient psychiatric facilities and the Internet.

Data Analysis

The data were analyzed according to the process described by Giorgi (1970). The researcher reviewed each interview for an overall impression followed by a secondary review to identify the meaningful units of data which included highlighting key words, attitudes, and values. The researcher restated the meaningful units into her own words and then considered the units within the context of the study's purpose. The final step was to develop a consistent description of the concept under study, first using the study participant's descriptions, and then the researcher's general meaning (Creswell, 1998). Findings were compared to representative policies on relevant topics. The resulting themes and subthemes are described in the summary of the research findings.

Results

Three primary themes emerged from the data analysis which focused on the precursors of assault, intervention strategies, and organizational and staff descriptors. Several of the primary themes were further classified into subthemes. The researcher describes a process of how the institutions prevent, address, and monitor assault in relation to representative policies, where applicable. Inpatient psychiatric personnel and administrator's perceptions of procedural effectiveness of the process are also provided.

Precursors for Assault

Direct care providers and administrators described their most recent assault experience, starting from the time they became aware that the patient was potentially going to act violently or they became involved in the assault. From these descriptions emerged the theme 'precursors for

assault.' The types of precursors were then subdivided into three sub-themes: patient illness and treatment, environmental factors, and risk identification. As noted in Table 4.2, these subthemes appeared across both groups of participants.

Table 4.2

Frequency of Subthemes for Theme 1: Precursors to Assault

Subtheme	Direct Care Providers N (Frequency)	Administrators N (Frequency)	Total N (Frequency)
Patient illness and treatment	7 (*f*=57)	7(*f* = 44)	14(*f*=101)
Environmental factors	6(*f*=14)	3(*f*=5)	9(*f*=19)
Risk identification	7(*f*=40)	6(*f*=33)	13(*f*=73)

Patient illness and treatment. The disease state of the patient and treatment emerged as precursors to violent behavior. Symptoms of mental illness could alter the patient's perception of routine events on the unit and could result in agitation and aggressive behavior. The symptoms described by the direct care providers and administrators included impaired insight, delusions, hallucinations, withdrawal from drugs and alcohol, and difficult social interaction. These symptoms and behaviors were known to be a workplace hazard by all of the participants. Levi, a psychiatric technician and direct care provider, expressed concern about the risk of being in direct contact with patients in the milieu, "I don't think we're safe-we're not". Jodi, a registered nurse (RN) and administrative leader discussed a request for additional staffing to address safety of staff caring for an ill patient, "People were not feeling safe being alone with her."

Kala, an RN and direct care provider, stated that the patient who assaulted her was fixated on her and having auditory hallucinations from the devil urging him to harm her. She made efforts to establish a therapeutic relationship with the patient following a prior assault but was not successful due to his psychiatric condition.

> Because I wasn't the first person that he hurt, he had it in his mind that ever since then, even when I would try to talk to him and we had a discussion about how I forgive him and how I just expect for him to tell me, talk to me when you're feeling this way, when he was having the auditory hallucinations. The devil was telling him to do these things. He just kept having this idea that I didn't forgive him and that I hated him. He told me that a couple of times before he acted out.

Administrators agreed by telling similar accounts of patient interactions. Hope, an RN and administrative leader described an assault in which the patient was psychotic and he assaulted the staff. The patient's altered perceptions led to aggression.

> [The] patient was disorganized, irritable, and did not have any medication and he had been that way for some time. By that, I mean several days, and they were medicating him PRN [as needed]. But that particular day, he didn't have anything, and he was so disorganized. His perception was off, because he thought I was somebody else. He thought my eyes were saying something to him that they weren't, because I tried to sit down and talk to him. You could sit down and talk to him, but he was just so psychotic. There was no way. He wasn't processing anything. He said, "Look at my eyes. See there? See there? You're lying. You're

> lying." So I said, "Okay, I'm going to get up," and I started to get up and move back—to move out of his way—and he followed me into the nurses' station but did not try to hit me. He only hit me when I tried to help another nurse...

Ineffective medication management was identified as critical in prevention and control for symptoms of agitation and aggression. Policies about preventing seclusion and restraint state the goal of administering medication is to provide "active treatment" to reduce symptoms of psychiatric illness. All medications and the specified dose must be clinically justified to reduce target symptoms and be consistent with safe practice. Patient refusal of medications can be a problem in the clinical environment.

Participants described patients who refused medication, were under-medicated, or who had drug addiction. Direct care nurses described a delicate balance of medication management between effective medication, patient safety, and use of medications to manage aggression in patients with addiction. Kala, an RN and direct care provider, expressed concern about the need to consider the patient's condition in writing medication orders. Kala said,

> The doctors are not giving [effective] medication therapy, they are overpowered with street drugs, and so that's a big problem. A lot of doctors started patients off with the basic medication. If the patient comes back, they start the patient back [with the basis regimen] over, and the staff has to nurture this patient back to health.

Otis, a psychiatric technician and direct care provider, made a similar comment, "[Medications should be] customized for that particular patient's size and weight and type of aggression that they have."

Administrators describe aggression and physical assault by patients who had ineffective therapy ordered for management of aggression. Once the patient's agitation level becomes a danger to the patient or others, the physician must be contacted for an emergency order of medication to be administered intramuscularly, under restraint if necessary. Administrators retrospectively review incidents to improve medication practices. Administrators report similar concerns about medicating the patient effectively without harming the patient. Vera, an RN and administrative leader, stated,

> So we're trying to get them to think about it, and get the nurses to, again, go back to thinking about that there's a balance in psychopharm between, you don't want someone drooling and shuffling and you don't want them punching and screaming and yelling. You want them to come to that nice, peaceful place. So that's what we're trying to teach the nurses, to be balanced.

Hope, an RN and administrative leader, discussed the need for the doctor to work with the nurses to provide effective medication to prevent assault. Hope said,

> [The doctor is] very important in giving us the medication we need for the patient. Listen to the nurse. ... the physician was not cooperative in giving us the medication that we asked for. He [the nurse] wanted the medication. He wanted to give it to the patient because he knew it was going to work, but the doctor did not

want to listen to the nurse. In fact, she didn't, and that's why it turned out like it did [patient assaulted staff member], I think. That's exactly why it turned out that way. So the doctor is key in helping us to give the patient what we need.

Employees are sometimes involved in numerous assaults before a patient is transferred or has received effective medication. Kala, an RN and direct care provider, was assaulted by a patient who assaulted her twice as well numerous other staff members. She said,

> There could be things that they have done, maybe between administration and the doctor, to get her [the physician] to understand the patient does need to go to Rusk [State Hospital]. I honestly do feel that this patient should have been managed differently, in a more timely fashion. Instead of him being here a month and a half.

Jodi, an RN and administrative leader managed an assault by a young female patient who assaulted eight people before effective medical management was implemented. Jodi described the change after having difficulty managing the patient's aggression, "Then they put her on some routine meds that helped, but it was a struggle because her parents really believed in the natural stuff and didn't want her on meds [medications]".

Nurse's described physicians as being cooperative by accepting suggestions about medication management, however, occasionally the physician disagrees with the nurse about the best treatment plan. Hope, an RN and administrative leader described an

occasion when a nurse requested a change in the medication management and the doctor refused,

> He [the nurse] wanted the medication. He wanted to give it to the patient because he knew it was going to work, but the doctor did not want to listen to the nurse. In fact, she [the physician] didn't... That's exactly why it turned out that way. So the doctor is key in helping us to give the patient what we need.

Participants referred to patient violence that stems from a bullying behavior where mental illness is not the cause of aggression and violence but is a day-to-day coping strategy that involves confrontation and intimidation. Some participants described patients who act out to establish control or who have poor interpersonal skills. Participants were in agreement that these patients do not need to be in the psychiatric hospital and should be transferred as soon as they have been adequately evaluated by the treatment team. Seth, a psychiatric technician, described the issue,

> ...sometimes we have patients and it [the aggression] has absolutely nothing to do with psychosis. I call it sometimes a "street mentality" to where aggression is just how they get their way, and they're out to really do you physical bodily harm.

Levi, a psychiatric technician, expressed a similar thought. He stated, "That's the type of mentality that happens in the jail system, not in a hospital setting." Vera, an administrator, describes the aggression as intentional, "...Some [patients] are completely psychotic, but some are sociopaths. They come in here with full will and they know what

they're doing...prison mentality, they do it [act aggressively] to gain control over the people on the unit."

Observations and restrictions provide more careful monitoring by staff or restrict privileges to prevent elopement or injury the patient or others. Restrictions could include a one-to-one or two-to-one observation, revocation of smoking privileges, and revocation of the ability to leave the patient care unit. One institution's policy regarding one to one observation mandate that patient behaviors that necessitate the type of observation and the behavior required to discontinue the observation should be documented. The policy did not address safety precautions for staff or alternatives to manage patient who continue to be aggressive despite the one-to-one observation.

Participants described restrictions as a measure that could either prevent physical aggression or act as a catalyst to cause aggression. The practice of a one-to-one observation requires the staff person to be within an arm's length of the patient at all times. Seth, a psychiatric technician and direct care provider, also felt that one-to-one observation could be a problem for patients. Seth said,

> Sometimes, it [one-to-one observation] can escalate it[aggression] because the person doesn't want to be treated different than they see the other people being treated on the unit and realize that they have some limitations and they always have somebody following them and watching them do everything, and that it can sometimes irritate a person.

Nell, an RN and administrative leader, described one-to-one precautions,

> We monitor them initially on precautions, sometimes on given restrictions. If they've shown or exhibited any of those behaviors, sometimes we'll order a one-to-one. I don't like to use a one-to-one for aggressive patients, because you just set the staff up for an assault. We like to use direct observations with one-to-one staff, but we always have somebody who can look and be able to observe the patient and their behavior, but not causing a lot of agitation.

Other restrictions include preventing the patient from leaving the unit for meals in the cafeteria, going outside, or smoking. Participants from facilities where smoking is allowed described smoking restrictions as a deterrent to violence or a cause of disagreement between patients and staff. Gabe, an RN and direct care provider, stated, "In fact, that [smoking restriction] was the number one cause of most of the problems." While Nita, an RN and direct care provider, described using smoking privileges as an incentive for patients, "For us it was a deterrent."

Environmental factors. A second subtheme related to precursors to assault was the presence of other patients and students or visitors in the milieu, termed 'Environmental Factors'. Direct care providers were more likely to identify issues in the environment as a precursor to assault than administrative personnel as shown in Table 4.2. Outsiders to the unit were described as a factor in several assaults. According to one of the reviewed policies, patients have a right to visitation; however, participants noted

that visits from outsiders could be a catalyst for violence on occasion. Kala, an RN and direct care provider, described a patient who acted out during family visitation, "Especially if his family came to visit, he acted out quite a few times when the family came."

The presence of nursing students on the unit may cause them to be a target for aggression by some patients. Intuitional training guidelines state all students are offered an orientation to the facility that includes safety topics such as monitoring for aggression. Levi, psychiatric technician and direct care provider, described an incident where a nursing student failed to follow instructions to avoid interaction with a particular patient. Levi was assaulted as a result of the student's involvement in the situation. Levi's description of the event was:

> This particular patient didn't want interaction with the nursing students. When I did notice that a nursing student had encountered her and they were sitting down and talking, I notified one of her peers and I said, "Hey, whisper in your peer's ear to move away from that patient, because you're not supposed to be with her." That nursing student started whispering into the peer's ear. She said it loud enough so the patient heard her and the patient became upset and went to the rest room. I didn't think anything of it, and all of the sudden, I was talking to one of the doctors, and the next thing I knew, the patient... just threw feces mixed with urine and blood in my face. It got in my mouth, my nose, and my eyes.

Erin, an RN and administrative leader, described an assault on a nursing student, "[The student] was just talking to the patient, and the patient attacked him, because he was very sick and refusing medication. We were in the process of giving court-ordered meds. He was really delusional, and he just punched the student."

An example policy from one institution requires that staff protect patients from harm and intervene in physical aggression between patients. Despite being trained in how to intervene, involvement in this type of incident places the staff member at high risk for injury. Gabe, an RN and direct care provider, expressed concern,

> It could be a nurse or ...one of the regular staff on the unit seeing things getting as what they perceive as out of control; either physical violence or patient escalating and feeling like maybe other patients and staff are in danger.

Vera, an RN and administrative leader, described the risk similarly, "The patient was agitated and threatening to assault other patients. The tech came and tried to dissuade him from doing that, and the patient turned on the tech and hit the tech instead."

Risk identification. The third subtheme associated with the theme, 'Precursors to Assault', pertained to the direct care provider's ability to recognize early signs of aggression and intervene prior to assault. A review of selected policies addressed training required for all employees during orientation and annually to detect early signs of aggression and identify underlying causes including the effect of the individual staff member's behavior on patient aggression. These skills are evaluated in the periodic competency review for each staff person.

Early identification of the signs of aggression is required to manage patient behaviors and effectively use PRN medications. Early intervention is important to diminish the presence of aggressive behavior in the milieu. Participants from both groups described the early signs of aggression that would prompt the use of verbal de-escalation, quiet time, and/or PRN medication for agitation. Descriptions of signs of aggression were consistent with following behaviors: pacing, clenching fists, balling up their hands, talking to themselves, cursing, talking loud, or withdrawing from staff and peers. Dyan, an RN and direct care provider, describes early signs of aggression, "Usually if they're pacing or grimacing, clenched fists, [bad] attitudes. Sometimes patients are threatening and really angry and yelling." Seth, a psychiatric technician and direct care provider, describes similar signs, "You realize when people clench their teeth, that they're upset; when they clench their fists, that they're upset; when they raise their voice; when they tell you to leave them alone they really mean, "Leave me alone."

Levi, a psychiatric technician and direct care provider, described the information from training about early signs of aggression. He said, "They tell us the clenching of the fist and when a patient is pacing back and forth, that's an immediate sign of a problem." Otis added, "Fists might be balled up. Talking to themselves [or] just staring out into space. You know something is going to happen." Vera, an RN and administrative leader stated,

> I would say psychopharm is a big aspect of that, being able to medically manage without over medicating but, at the same time, being able to help a patient to

manage their own internal stimuli so that they're not punching everyone that walks up to them.

Participants described incidents in which the patient assaulted the staff with seemingly no early sign of aggression, however, the participant's interview reveled possible early signs that were undetected.

Nita, an RN and direct care provider, described a common conversation about medication and then an assault event as starting suddenly without warning,

> I knew him. He had been with us previously, probably 3 weeks before, but he stayed with us like 2 months. So he came up to me, and he had a nickname for me honeybee. He was talking through the glass. It had a little hole in there. He was talking through the glass, and he says, "I think they've been giving me the wrong medication. They haven't been giving me my pink pill—my Seroquel." I said, "Well, when you were here before, the pink pill was your heart medication." And he says, "Don't argue with me. I know what I'm talking about." I said, "Okay. Let me come out and go to the medication room and look on the computer to see exactly what the pink pill was." ...I put the key in the door, and he came running down the hallway—I didn't see him—and hit me on the right side of my head, knocked me out. When I came to, he was sitting on my chest, pounding my face.

The patient's argumentative remarks may have been an undetected early sign of aggression.

Jodi, an RN and administrative leader, described a teen that assaulted a physician, "She seemed to be very unpredictable in her assaults and would catch people off guard". Jodi added that this patient had a history of assaulting seven other people in a similar manner during her admission. The patient's history may have been an early sign of aggression.

Intervention Strategies

The second theme that emerged was the actions taken by direct care and administrators once assault occurred. The exemplar quotes for this theme were further classified into four subthemes: addressing aggression, emergency code response, seclusion and restraint, and emergency medication. The frequency with which subthemes appeared across interviews and across data is presented in Table 4.3. Direct care providers were more likely to identify the hands-on clinical aspects of restraint, seclusion, and emergency medication, while administrators were more likely to than direct care staff to identify an emergency code response that triggers an administrative response and reporting.

Addressing aggression and protecting the patient. This subtheme for procedures to address violence refers to attempts to talk to patients and resolve conflict or quiet aggression prior to physical intervention. If physical restraint is required, policies reviewed indicated that only properly trained personnel may intervene with a physical hold intended to contain the patient without causing harm to the patient. These policies described the patient behaviors that necessitate a verbal de-escalation and/or a physical

hold as: confusion, disorientation, extreme restlessness, agitation, hostility, or aggression that may cause injury to themselves or others. Staff may also use a physical hold if the patient attempts to ambulate without assistance when assistance is required to prevent injury from fall.

Table 4.3

Frequency of Subthemes for Theme 2: Intervention Strategies

	Direct Care Providers N (Frequency)	Administrators N (Frequency)	Total N (Frequency)
Addressing aggression and protecting the patient	7(*f*=25)	5(*f* =13)	12(*f*=38)
Seclusion and restraint	7(*f*=15)	5(*f*=8)	12(*f*=23)
Emergency code response	6(*f*=12)	4(*f*=29)	10(*f*=41)
Emergency medication	5(*f*=14)	5(*f*=8)	10(*f*=22)

Direct care providers and administrators had a consistent description of verbal de-escalation and found the technique to be a valuable tool for reducing aggression. When signs of aggression were identified, participants used a verbal de-escalation technique in an attempt to avoid a physical intervention. The staff talked to the patient to determine the cause of agitation and removed it if they could. Staff reported having a therapeutic conversation to point out the objective signs of agitation to the patient and offer to allow the patient to spend some quiet time in his or her room and possible take a PRN

medication for agitation. Some patients could be de-escalated with a snack or cup of coffee. Other patients needed re-direction with an activity.

Levi, a psychiatric technician and direct care provider, described the value of using verbal skills with patients, "You use eye contact and let them know you're not going to hurt them, you're going to help them, and you're on their side, let's work together. If you can get them to feel like you're a team, you won." Dyan, an RN and direct care provider, described a successful patient encounter, "The staff talked with her...trying to talk with her and see what happened and calmed her down a little bit, and then we gave her something to drink."

Erin, an RN and administrative leader, described the need for therapeutic communication. She said,

> For psychiatric nursing, it's searching for a change in behavior, increase in pacing, change in facial expression, and the tone of voice. You could just tell. Those are the things we observe—any change in a patient's behavior. Any signs and symptoms of agitation, anxiety, and any triggers: other patient's, phone call from the family, doctor's interaction that did not go well. Those are all of the things we observe. So it's being communicated, and once we see that, the psych tech will tell us, "So-and-so is getting angry." If we don't see that, we won't catch it, and then the psych techs will actually encourage them, ask them what going on, administer their meds, and ask them if they can come down on their own so we don't have to give them a shot. That kind of communication is very important in a team.

Participants who identified early signs of aggression used verbal de-escalation to try to avoid a physical intervention. Skills required for verbal de-escalation relate to the ability to talk to the patient calmly and confidently. Some participants described distraction or re-direction such as getting a snack, allowing quiet time or taking a walk.

Direct care staff reported on technical aspects of the physical intervention whereas, administrative personnel were more likely to focus on avoidance of physical intervention. Jodi, an RN and administrative leader, described a desire to avoid a physical intervention. Jodi said,

> I think the team is trying to de-escalate the person first. They try to see if they can verbally intervene and deal with them. With her, there was no—it was very limited opportunity, I think, because it just happened, and we didn't get someone building up and being angry over something they're meaning or it wasn't clear. So I think people still tried to deal with that and give her some space, see if she could calm down rather than try to—not intervene physically unless we really had to.

Each member of the team is responsible for identifying and communicating potential aggression. Communication between the psychiatric technicians and the nurses was described as crucially important to early identification of signs of aggression and effective medication management. Seth described the importance of communication,

> It's [communication] vital. Without it, you're going to have it [violence]. I think if you can trace back aggression..., with very few exceptions, it could have been

prevented, if communication was good and observations were good and things were passed on in a timely manner."

Erin made a similar by statement, "That kind of communication is very important in a team, because without that [communication] they [the patient] could be all over the place, and the psych tech is just standing around and seeing something, they should alert us."

Communication between the psychiatric technician and the nurse allows the nurse to share historical information from the notes prior to admission, the patient record, and the shift report to alert the technician to a history of aggression. The technician's role is to be in the milieu interacting and caring for the patients. The technician has the closest contact with patients to observe the early signs of aggression and inform the nurse.

Seclusion and restraint. The next subtheme refers to placing the patient in seclusion or restraint to subdue physical aggression. Policies describe seclusion as an involuntary confinement in a space where the patient is not allowed to leave. Restraint is a method of physically preventing a patient's freedom of movement and includes the holds used in a physical intervention as well as mechanical restraints, although mechanical restraints are rarely used and were not described by participants. One institution has a philosophy statement regarding the use of seclusion and restraint that describes seclusion and restraint as "high risk and problem prone". The hospital is committed to using the "least restrictive alternative for patient care and limiting the use of seclusion and restraint". According to the policy of one institution, the use of seclusion

and/or restraints is limited to emergency management of a patient's threat to harm himself or others. Seclusion and restraint are not to be used in a manner that is punitive, for staff convenience, or that may cause pain or discomfort to the patient. The definition of restraint in the policy extends to include the temporary physical hold used in the physical intervention. Levi, a psychiatric technician and direct care provider, described the physical intervention that occurred when verbal de-escalation failed to prevent an unsafe situation and the risk of violence was not identified until an unsafe situation existed.

> We did a two-man takedown...When I grabbed her, it's like she knew what she was doing,...she knew she threw something at me and hit me. She knew she would be taken down. When I did the two-man takedown, ... and [the female technician] and I sat down. She had the floor, and I had the upper body and held her until the nurse got some medication. We covered her with a sheet to respect the lady. We did the exact procedure, two-man takedown. That was perfect.

Dyan, an RN and direct care provider, remarked,

> I think part of the problem is the patient comes from another place [other psychiatric facilities], and they expect really physical holds, and so they're going to fight and become even more assaultive, no matter what you try to explain to them.

A policy from one institution states, that the determination of need for seclusion or restraints rests with the nurse; however, a doctor's order must be obtained within one

hour following the intervention. The nurses in the study gave a description consistent with the example policy. The determination of need for seclusion and or restraint were made on a case by case basis and was not an automatic result of physical aggression. Participants described an assessment of the situation in which a determination was made about whether the patient's aggressive behavior had concluded. Consistent with the policy, heavy emphasis was placed on making sure that seclusion and restraint was used therapeutically and not in a punitive manner. Seth, a psychiatric technician and direct care provider, described a therapeutic use of seclusion,

> We picked the patient up and helped him get on his feet, and we led him to the seclusion room. We put him in the seclusion room. We didn't lock the door, but we had the patient just stay there for about five minutes [to] ten minutes or so. Just to kind of settle down. Normally after the patient settled down and is not aggressive, we can ... let the patient come out. They realize that they were out of control. And the staff as well as the patient realizes this is not punitive. We're not trying to punish you, but you were out of control and we're just trying to get you to calm down, it works well, I think.

Hope, an RN and administrative leader, stated similar thoughts about the use of seclusion,

> Because the verbal intervention comes in. We tell them—you know—you can control this. You don't have to be locked up. We don't want to lock you up. And seclusions are not necessary. Our seclusion rate should be down. I'm not sure what it is, but it's very much down. The special teams [code team] come, but the

seclusion rate is down because most often they don't seclude. They've got to really be fighting and try to hurt us before seclusion.

Administrators encourage low seclusion rates. Reporting measures to Joint Commission require that data on seclusion and restraint be maintained and the data is heavily scrutinized due to the risk of patient injury. Vera, an RN and nursing administrative leader, described her institution's policy to reduce seclusions,

> It speaks to utilizing less restrictive interventions prior to that. It does speak to assaulting another patient as being a potential reason for seclusion—aggression of that nature. Because we want to justify the seclusion being when someone is a harm to themselves or others, that they require that level, and typically when they're harmful to others, they have to be secluded.

Rene, an RN and administrative leader described the incorporation of patient de-briefing information into annual training to help staff understand seclusion from the patient's perspective. Rene said, "When they [staff] do their annual training, that information is shared with staff, the patient's feelings about the seclusion and restraint."

Patients may request time in the seclusion room. This would be a therapeutic use of seclusion, although, depending on the implementation, it may be considered to be quiet time if the patient voluntarily goes to the room and the door remains open. Gabe, an RN and direct care provider, described a patient request to go to the seclusion room.

> It's almost the same. If the patient becomes aggressive or if the patient maybe seemed very upset about all that, then the patient has to be taken under seclusion

and the patient gets depressed, you know? "I feel I'm going to hurt this person, so kindly take me to the seclusion," so sometimes, the patient requests.

Seclusion is a clinical tool used for managing agitation and aggression, however, physical intervention does not always lead to seclusion. If the patient was involved in a physical intervention and is no longer aggressive, the patient would not be placed in seclusion. This practice is consistent with the goal of the policy to be non-punitive and to maximize patient safety by using seclusion no more than necessary to manage behavior that could injury the patient or others.

Emergency code response. The next subtheme refers to the gathering of trained personnel in response to the call of an emergency code for escalating aggression. Example policies state the purposes of these codes are to provide additional assistance to bring the situation under control without injuring the patient and maintaining the safety of the staff and other patients. Inpatient psychiatric personnel and administrators reports were consistent with the sample policy in regard to the purpose of a code for emergencies; nevertheless, actual clinical practice differs from the policy. Some participants report being asked by administration to call a code for all emergency medication episodes. A policy from one institution, stated that the decision to call should be directed by the RN except in the event of "imminent danger".

All participant descriptions were consistent on the procedure to call an emergency code. Participant's reported calling the code which resulted in trained staff, and in some cases, administration and/or security personnel came to the patient care unit to provide

additional support. One institution required that a code be called for all emergency medication episodes. Some participants' criticized that requirement by stating that the event was so brief, it was over before the emergency code could be called. Levi, a psychiatric technician and direct care provider, reported that the event was over before the team arrived. He said, "She already did what she wanted to do! She was done, she was on the floor, and we gave her the medicine, so we didn't need any more backup. We had enough staff and we had staff appropriately handle it." Jodi, an RN and administrative leader, described a similar event when she stated, "I think there were other times they didn't even call a show of support [code] because like I say, it happens so suddenly."

Events that required assistance from the code team were complex and required coordination of the arriving personnel and calling the physician for medication orders. According to example policies, the charge nurse is the leader of the team response despite participation by more senior leadership. Jodi said,

> Yeah, I think the RNs are considered to be in charge of the codes, usually, and maybe the one getting the medication and orders. The other one maybe a lot of the time is with the patient. Like I say, they're involved with—they're in the midst of the interaction with the patient. Sometimes my experience is that person isn't able to direct the whole team because like I said, their interaction with the patient and their focus is trying to get the patient calmed down and negotiate with them.

Gabe, an RN and direct care provider, sums up the code response, "It's just to help with restraining, yes. Just like teamwork." The code assists staff members with a rapid response of trained assistance to manage physical aggression in a controlled manner, attempting to prevent injury to patients and staff.

The presence and role of administrative personnel and security personnel were variable between the four institutions. Both administrative and security personnel were present to support the code team but not to manage the code. Administrative personnel may direct personnel arriving on scene for the code, assist the nurse in reaching the physician for the emergency medication order, and, on occasion, help put the patient in a restraint hold. The security personnel could participate in the physical intervention but the availability of the security personnel was variable and they would use the same techniques as the direct care provider.

Emergency medication orders are a part of the emergency code process. The orders are obtained from the physician when routine and PRN medication management has been ineffective to halt the progression of aggression. Example policies mandate that the nurse contact the physician for emergency medication orders prior to the administration of injectable medications. Participants described the process of obtaining orders from the physician. Nita, an RN and direct care provider, commented on the process of getting an order for emergency medications in the teaching hospital where she works,

> We have to go to the on-call doctor. Once that on-call doctor puts it in [the medical record] ...you'll see the orders there, but they won't be released from the pharmacy, so you have to call the pharmacy and say, "Release these now." Because we have a lot of residents, sometimes they change their mind, and in order to protect your license, you have to make sure that it's on there. There's no such thing as a verbal order at that institution.

The two groups were in agreement that emergency orders are not included in the standing order set and must be obtained at the time of the intervention. Rene reports, "We used to have standing orders but it was dangerous [for patient safety]. Joint Commission doesn't like standing orders." Participant descriptions of the efficiency of the process to obtain orders for emergency medications varied. Some participants reported that the physician was readily available and immediately ordered effective medication, while others, reported difficulty reaching the physician or physician hesitance to order fast acting, effective medications.

Vera, an RN and nurse administrator described a recent process change to speed up the process of obtaining an emergency order in a teaching hospital. She said,

> Sometimes they'll manage a patient and they'll take a patient down and they'll be waiting for the emergency medication and the resident or the faculty member may be off doing other things. So what we're doing now is we're asking the house officer, who is the resident on call, whenever they hear a special team [emergency code], to call the unit immediately—to pick up the phone and call the unit or go to

the unit. And that's really helped a lot, because now the doctor is right there and can go ahead and give the IM, the Ativan, whatever.

Participants describe a good response to emergency medication once the medication has been ordered and administered. Kala, an RN and direct care provider, said, "By the time the medicine took effect, he was manageable."

Organizational and Staff Descriptors

The last theme identified are the perceptions from direct care staff and administrators of the activities and infrastructure provided by the organization and the individual factors for each staff person that prevent, monitor, and address assault. Subthemes for Organizational and Staff Descriptors are the role of administration, staff considerations, and emotional intelligence. The frequency with which subthemes appeared across interviews and across data is presented in Table 4.4. The subthemes are explored individually in the following paragraphs. Administration was more likely to discuss their traditional roles than direct care providers, however the direct care providers were more likely to identify issues specific to staffing the patient care unit with an appropriate staff mix. Both groups identified and discussed the qualities of emotional intelligence.

Role of administration. This subtheme for Organizational and Staff Descriptors refers to roles and functions of administration including development of policies and procedures, fostering a supportive work environment, managing quality improvement activities, and development education and training. Each participant was asked about

policies related to prevention and management of assault such as policies related to codes, emergency medications, and seclusion. Administrators were more likely to identify this theme than the direct care providers. Some participants were not supportive of policies for prevention of assault. Levi, a psychiatric technician and direct care employee stated, "I don't think anything a person could write can prevent you from being hit. The best thing that the person can write can say, "Run." That's the only prevention from being hit." Nita, an RN and direct care employee had a more pessimistic view, "[policies] have a whole bunch of them. Do they make any sense? No."

Table 4.4

Frequency of Subthemes for Theme 3: Organizational and Staff Descriptors

	Direct Care Providers N (Frequency)	Administrators N (Frequency)	Total N (Frequency)
Role of administration	7 (*f*=63)	7(*f* = 110)	14(*f*=173)
Staff considerations	7(*f*=107)	6(*f*=49)	13(*f*=156)
Emotional intelligence	6(*f*=24)	5(*f*=30)	11(*f*=54)

None of the participants, from either group, were able to speak with certainty regarding the content of polices. Vera, an RN and nursing administrator discussed seclusion and restraint but had difficulty recalling the content, "There are specific, I'm just trying to, in my brain...We've got 200 [policies], so I'm trying to remember if that is its own specific or if it's a carve-out." Erin, an RN and nurse preceptor, tried to recall a

process in policy, "I'm thinking about that policy; I'm not sure if it's in the policy or not. I'll have to review that. I knew looking back, it's a practice we've been doing. Maybe it's somewhere in the policy."

Participants were aware of procedures such as code response, emergency medication, and seclusion but these were described as a part of the culture rather than processes mapped in policy; nevertheless, policies reviewed supported the procedures that direct care staff and administrators described. Participant accounts of procedural activities were consistent within and between organizations on these critical roles in psychiatric specialty care. Despite administration's efforts to provide injury management programs, direct care participants described insensitivity from managers following injury. Levi, a psychiatric technician and direct care provider, stated, "No one came to me and said, "Are you okay?" If someone just came and said, "Are you okay?" The wrong thing to say is, "I know how you feel." Nita, an RN and direct care provider, was off work for 12 months without communication from leadership. She said, "The last person I heard from called and then I had to go in and I had to sign my papers saying that I'm off work with leave without pay." Kala, an RN and direct care provider, elaborated on her needs following the assault, "Our personal experiences, ...they need to be addressed. We need to be listened to. We need to debrief. I would like for my supervisor or someone to come and meet with me and talk to me about the situation."

Perceptions of administration's response to assault are mixed. The response to assaulted workers is not formalized in policies or protocols reviewed by the researcher beyond the procedural steps to obtaining workers' compensation care.

Another administrative role is to collect data to be tracked and trended and identify opportunities for improvement. The data on patient care events and staff injuries is reported to all leadership and the unit employees. The information is used to benchmark the institution against themselves and local and national benchmarks to gauge the quality of performance. An example policy related to event reporting states that the reporting provides a mechanism for collecting detailed information for the purposes of documentation and study of quality services. These documents are to be generated anytime that an event occurs that is not consistent with routine care of a patient, including emergency medication or seclusion and restraint.

According to the seclusion and restraint policy of one institution, it is the responsibility of the RN to document the information on the appropriate forms and submit the forms to his or her head nurse and the hospital administrator. All staff involved in the patient care activity are listed in the report. Staff involved are required to provide a narrative description of the entire intervention including the patient's behavior that prompted the event. The names of witnesses are listed and a description of the event from the patient is obtained after the patient has calmed down. Occasionally, the patient will refuse to make a statement. The completed report is filed in the patient's medical record. Gabe, an RN and direct care provider, described the process,

> The nurse is the one to fill everything [paperwork], and the nurses; they just make it simple for the patient, like if the patient was treated in a proper way, was their privacy considered or something like that. So I guess that's just to make it simple on the patient. The patient actually doesn't write it. You just ask the patient and then you fill it [the information]. The problem sometimes, the patient doesn't want to respond because it seems to them at the time that the [other] patient has been aggressive. So sometimes you just have to maybe admit something for the paperwork, when just the patient was abusive or something like that... It goes into the patient chart.

Nita, an RN and direct care provider, described inconsistency in the process. She stated the following,

> We do place it in the chart, but for our paperless system, this is a paper form, so depending on if somebody doesn't write it in their chart...then nobody knows. Even if you flag it for the doctor to see, half the time they don't read it, so they don't know that this person was a [the source of a code] the day before.

Documentation in the patient's chart is critical information for review of quality processes related to safety of patients and staff.

The written report of employee injuries is required by the Workers Compensation Division at the Texas Department of Insurance. The reporting of injury seemed to be routine; but, the process of seeking care was perceived as disconnected and focused solely on physical injuries. A need for mental health and co-worker support was

identified by direct care participants; however, supervisors are not consistently referring injured workers to counseling resources. Nell, an RN and administrative leader addressed referral to the employee assistance program (EAP) as a part of the injury management process,

> ...sometimes some of these injuries are very traumatic. Some managers are pretty good at offering EAP and some are not. I think a lot of times; we look at the physical injury and not so much the emotional injury. It can get tough coming in here dealing with very hostile, threatening people; cursing, fighting, and that kind of stuff. Sometimes, I know for myself, I've been given some EAP referrals.

Bree, an RN and administrative leader, talked about employee reporting and using the healthcare resources available to the employee. She said,

> I don't think they were discouraged [from using EAP]. I think ...to go through the process of reporting and then going through it [the clinic visit]. They say when they go to employee health service, it takes a long time and they [employee health] even ask, "Oh, okay, are you sure this happened?

The last type of event reporting refers to an internal incident report for the purposes of quality improvement and to inform leadership of the event. Participants in both groups stated that this report was generated when deviations in patient care occurred including seclusion, restraint, assaults, or patient injuries. Rene, an RN and administrative leader, described the process for reporting the event,

> They have to fill out a ...report on any type of incident that occurred with a patient [such as] assaults, [or] just any type of unusual incident. If something happens, they have to fill out [the report] whether or not an injury occurred. ...I'll put in my recommendations, and ...it has a list of every manager on the unit including the CNO [Chief Nursing Officer] and then of course [Quality] and [Safety], and then I'll write my note in here. I'll check ...patient practice patterns or refer to root cause analysis or training facilitator, any of those things.

Nell discussed a process derived from data analysis in which newly admitted patients with a history of physical aggression during a prior admission triggered an alert to let staff know that the patient had a history of violence. Nell stated,

> Once the patient is admitted, it alerts them that the patient has come back, which is the admitting process downstairs, alerting them that the medical record number has come back into the hospital, so it alerts in the report that at one time, there was a Patient Care Variance that was placed into the system, showing the patient was either high risk for violence or had violent behaviors.

These reports are important to the quality processes and trigger actions based on review of the incidents. The administrators spoke to how data are gathered from reports that track and trend events and interventions planned for issues identified. Despite efforts at performance improvement to develop communication specific to a patient's history of aggression, there continued to be single source for staff to find information on a patient's history of aggression.

Vera, an RN and administrative leader spoke about monitoring the data from event reports and other data,

> So we started doing that, and with the exception of one month...we have pretty much seen our assaults be at a much better level, [a] much more manageable level, and well within our control. I think we've only had one month in the last twelve months where we were outside of our own control chart for ...patient-on-staff assaults.

Several direct care participants' spoke about receiving quality reports detailed by unit. The reports are brought back to the unit and discussed in a staff meeting and posted for all of the staff to review. Administration seeks feedback from staff to find opportunities and suggestions for change and to gain staff cooperation in facilitating change. The process is intended to be non-punitive and constructive. Seth, a psychiatric technician and direct care provider, said,

> It's [review of data] real valuable, to me it makes you look at it and think you're doing a pretty good job. You know, you're good, you have good rapport with the patients and the unit and everything, and it makes you feel like you're doing a good job.

Bree, an RN and administrative leader described the nature of the conversation between manager and staff,

> They [the staff] kind of go over it [the data] and kind of look at, "What do you think we could have done different?" It's not a punitive session; it's just a review

session just to look to see whether or not we really did the best thing. Did we do the best thing for the patient? Did we do the best thing for the staff?

Dyan, an RN and direct are provider described a change based on quality reviews. She said, "The code sheet that we use for seclusion and restraints were changed a little bit and updated."

Administration develops and offers training to staff for nonviolent crisis intervention. Staff receives nonviolent crisis intervention training at the time of new hire orientation, annually and, at one institution, in follow-up of repeated injuries. The training included the information on the crisis cycle and skills related to recognition of aggression, verbal de-escalation, and physical intervention. The effectiveness of the training was variable depending on the situation with the patient and the staff's fitness for duty. Dyan, an RN and direct care provider, discussed the effectiveness of training, "I've seen it work maybe about 80-85 percent of the time effective."

Criticism of the training from direct care providers focused a poor translation from classroom practice to actual care of a patient. Kala, an RN and direct care provider, explained her experience, "[Nonviolent crisis intervention] was not effective for this patient. He would get the idea and act on it." Gabe, an RN and direct care provider, made a similar statement, "[Nonviolent crisis intervention technique] it's very effective with certain patients, [but only] patients that are willing and able to process." Jodi, an RN and administrative leader, cited a lack of opportunities in institutions with few violent patients to use and practice the skills learned in training. Jodi said,

> [The need for physical intervention] happens so infrequently, what I find is people come and they kind of are frozen, and maybe it's been six or seven months since they took the training and they don't seem to remember what to do.

Other concerns about the training relate to the application of the technique for staff who are short in stature or who have health issues such as osteoarthritis. The physical hold techniques require that the staff member place his or her arms around the patient from the back in a type of hug. Large or tall patients were difficult for staff members to control if the staff member was smaller than the patient either because the staff member's arms could not reach around the patient or the staff member's arms were not correctly located across the chest to contain the arms of the patient. Staff members who are obese or who are in poor health might not be able to put the arms around the patient or make a controlled descent to the floor while holding the patient. Levi, a psychiatric technician and direct care provider, explained, "It works if you're performing it correctly. If you were not physically fit to do that, it's not going to work for you."

Administrators and direct care providers were divided on the issue of re-training of staff who were injured in an assault. Vera, an RN and administrative leader described the education,

> So we started...sending the employees that were the victims of any assault wherein there was an injury we started sending all of them, and now also the nurse in charge, to a separate little class that's only about an hour long that is conducted by the same people who teach our [nonviolent crisis intervention]

class. So they now go over an additional—like a booster shot of education to go through what occurred, what they could do differently next time, re-educate them on steps in the process that they might have missed, try to help them to be less reactive and more calmer and more verbal in the event, and really be able to determine when it is imminent danger and when it isn't.

Levi, a psychiatric technician and direct care provider, discussed his thoughts on re-training. He said, "[The] way they're [administration] managing it is if you get hurt so many times, we were told that they're going to send you to remedial training, saying you're not sharp enough to work on the floor." No alignment regarding the purpose of the training was identified between the two groups. Direct care staff viewed the remedial training as unnecessary or punitive. Participant's identified some best practices in terms of communication including the use of shared governance to approach the topic of assault with administration.

Staffing considerations. This subtheme for Organizational and Staff Descriptors captures comments that addressed the subjects perceptions of staffing adequacy, experience, gender differences, and working relationships with physicians. Concerns about staffing relate to the numbers and skill mix of staff. Direct care staff were more likely to identify this subtheme than administrators. A representative policy states that staffing levels and assignments should be established to minimize the possibility of seclusion and maximize safety. The policy gives guidance that staff qualifications, acuity, and patient needs should be considered in the staffing plan. Participants emphasized that

the staffing schedule should be sensitive to a balance of experienced and new employees. Gabe, an RN and direct care provider, described the staffing method, "somebody in charge of staffing just types a calendar to see, okay, this person is going to fit this space." Last minute changes also contribute to the burden, Dyan, an RN and direct care provider, said, "Staff call in sick or they're not there and we're limited [on staff]." Gabe explained about competing demands when working understaffed. He said,

> I was assigned to some patients, and there's no "psych tech". Normally, because it's supposed to be the "psych tech" that takes the patient to smoke, but during that time, I was the only nurse...so if I'm doing labs, I have to prioritize medications.

Otis, a psychiatric technician and direct care provider, added other patient concerns, "A man might try to sneak a woman in the room... [And] while we are over here looking at this a fight will break out..., and there are two fights with only two people [on staff]. You can only do so much."

Direct care participants report that supervisors will help on the unit if there is a high acuity patient or the supervisor may arrange to float an employee from another unit. A formal solution of increasing staffing was being planned at one institution based on high activity times when staff is busy. Erin talked about administration's attempts to respond to staffing concerns. She said,

> Administration has been supportive of decreasing the assaults. Extra staffing has been implemented, we're going to have an extra 13 support techs that will be

> added to the unit. The patients are too much. The work load is a lot, and we're getting more patients. We've been advocating for increased staffing where the high activity is, which is 11:00 am to 7:30 pm from the morning when discharging in admission, visitation time, that's where there's increased staffing, two techs and two nurses in the afternoon.

Many variables involved in managing staffing were identified including call-ins, scheduled time off, patient census, patient acuity and activities on the unit. Administrative personnel stated that 'on demand' measures are available to temporarily increase staffing and assist with a crisis. One institution has recently approved a plan, based on data from the quality improvement process, to have increased staffing during the busiest times of the day when the doctors are in rounds and during visitation hours. Direct care providers expressed encouragement for this type of long term planning to address staffing concerns.

Ensuring a mix of staff on the shift with experience and longevity with the institution was a concern voiced by many of the direct care staff. Experience and longevity are required to safely work in an inpatient psychiatric facility. Experienced staff has had annual training and years of opportunity to practice skills related to avoiding assault by recognizing and addressing aggression early. Erin, an RN and clinical preceptor, explained her first assault experience as a new nurse,

> I got hurt in my first three months of psychiatric nursing. I thought I'd leave psychiatry. I would have left because of the injury I had. I was kicked in my

stomach several times, my hair was pulled out. It was too much for me to take, but it took one person, a manager, who told me she got hurt and learned from it. She said I'd be a better nurse from it. I learned, came back, and after a year, I became assistant nurse manager. I have learned and I didn't get hurt for a long time. Every injury you have, you learn. Experience has a lot to do with it.

Gabe, a new nurse with two months of experience stated, "The worst mistake was after the three weeks of orientation, then I was left with another new nurse, so I didn't have anyone to give me direction." Kala, an RN and direct care provider, acknowledged the value of experienced staff, "I think that if you have an experienced tech on the unit versus someone who is new and may not be as educated in how to handle these situations, it would be more effective." New staff must be trained and have the opportunity to practice along with an experienced team.

Participants described the issue of gender differences in communicating with patients. There was discussion about whether male verses female providers were better at therapeutic communication but the main emphasis was that these differences are patient specific and not specific to one gender being generally better at communicating with patients. Seth, a psychiatric technician and direct care provider, discussed the importance of gender,

It's very important. Even culturally, you have to keep all of it in mind because we have such a variety of people that we're dealing with. Some men do not accept

anything from a woman. Gender is very important. I've seen totally different responses from patients based on gender.

Dyan, an RN and direct care provider, gave a similar description,

> I don't think one [gender] is better than the other. It just depends on the person. Sometimes a male patient can get along or feel more secure with a female patient, and then other times, talking to a nurse or a tech that's male, because a female would understand the problem better. It just depends, I think.

Participants described the support provided by team members to accomplish the work of managing aggression on the unit. Direct care staff described working relationships and managing aggression as a team effort. Dyan, an RN and direct care provider, explained,

> I think it's a combination of things, ...let's try something else first [before seclusion or restraint] and see how that works and kind of get all your staff on the same wavelength, as compared to ... I think we should do this, I think we should do that. If they're kind ... on the same mindset, let's try other things unless we absolutely have to seclude or restrain.

Seth, a psychiatric technician and direct care provider, made a similar statement,

> [Teamwork] is vital. I think if you can trace back aggression, I would say almost 9 times out of 10, with very few exceptions, it could have been prevented to where you needed now orders to give, if communication was good and observations were good and things were passed on in a timely manner.

Participant's described an out pouring of kindness from other direct care providers following an injury from assault. They noted that co-workers provided first aid and concern to other members of the team. Direct care and administrative personnel stated a collective understanding regarding the risk of violence present on the nursing unit

Emotional intelligence. The last subtheme for Organizational and Staff Descriptor refers to the ability of the staff member to provide patient care to a patient who is exhibiting aggressive behavior without responding to the patient with similar aggressive behaviors. Institutional policies state that training for staff includes teaching self-awareness about how the provider's behavior is perceived by the patient. The exemplar quotes for this theme relate to self-control, situational awareness, and establishing a rapport. The frequency with which inpatient psychiatric personnel and administrators addressed this theme was similar.

Administrators described addressing aggression by having insight into their own behavior and responding with empathy rather than confrontation. Following his description of the assault, Levi, a psychiatric technician, and direct care provider, stated, "I did well to hold my composure." He described hurtful patient behavior, "we have had people say racial slurs and it's very hurtful, but ...that staff person has to try not to take it personal and...to [not] retaliate verbally."

Jodi, an RN and administrative leader, had a similar description of the staff's reaction to the assault she managed, "Staff had to really work hard to not take it personal

and it's really hard when someone slaps you in the face or is hitting you about the head...to not take it personal."

Vera, an RN and administrative leader talked about efforts to reframe the staff's perception of patient aggression and react to verbal abuse and escalating aggression with a calm demeanor and creative solutions. Vera said, "So we're trying to get the staff to react less and think more. Be in charge of behavior, don't react to it. Realize that you can manage this behavior if your reaction is appropriate...think what this guy's really feeling." Administrators suggested responding to patient emotion with empathy and redirecting the patient's attention to avoid confrontation.

Situational awareness refers to the staff being aware of the risk of danger on the unit and dealing with the situation before it becomes an issue. Staff members monitor the unit, identify patients at risk of aggressive behavior and seek interventions to prevent escalation. During times of aggressive confrontation staff seeks creative solutions to defuse the situation. Jodi, an RN and administrative leader describes interaction with adolescent boys,

> Boys would tell me that they have liked a code; they don't hurt women and stuff like that, so I would know that I could get close and talk with them and de-escalate them and they're not going to harm me because they'd kind of tell me they wouldn't.

Seth, a psychiatric technician and direct care provider, detailed a similar event,

> I responded to a special team one time, and usually, when we respond to special teams, we put on gloves in case we have to handle the patients. The patient who the special team was called for noticed something was going on, so he saw everybody with those gloves on, and he threw out some expletives and said, "I'm going to whoop everybody who shows up with those gloves on. So I took my gloves off because that is what was escalating him at that particular moment. Just taking off the gloves, I was able to approach the patient and talk to him and verbally de-escalating him in the situation.

Retrospective review of aggressive incidents could improve understanding and develop new strategies to address de-escalating patient behavior. Seth described the process, "So it's just something you have to keep in mind and not take it personal. When you have one [an assault], each one is not going to be the same, but you build, you learn what your mistake was." Levi offered a similar thought, "Sometimes you say, "Why didn't I give that patient an extra cracker?" Why didn't I talk to this person and take them outside?"

Patient rapport refers to the ability of the staff members to develop kind and respectful relationships with patients. A philosophy statement from one of the organizations espoused that the patient is the most important person in the hospital. Participant descriptions of kind interactions between staff and patients were found throughout the interview transcripts. Both direct care and administrative staff repeatedly expressed a desire to manage aggression without harming the patient. Thoughtful

interactions between staff and patients were described. Gabe, an RN and direct care provider, discussed communication with a patient during a takedown, "You're still trying to reassure the patients that we're just here to help them." Seth, a psychiatric technician and direct care provider, talked about the skills necessary to develop rapport,

> A lot of people think that your experience has to be in psych because they see psych people as different. ...when I train people, I tell them their experience needs to be with people ...your people skills are what are important. So it's learning how to deal with the people, dealing with a person. Everybody responds to kindness. Even those that are aggressive, it's hard to argue with somebody that's not arguing back with you. It's hard to be cruel to somebody when they're being respectful to you and treated you kindly and you really had no reason other than you just want to be aggressive to hurt them and be in that manner.

Otis, a psychiatric technician and direct care provider, added,

> Building rapport is like you're trying to build somewhat of a friendship with them. It could be the smallest little things, you know. Talk to them. Listen to them. Maybe if they come in having a hard time, [say] "Here's a cup of coffee."

Summary

Inpatient psychiatric personnel and administrators gave similar descriptions of their experiences with patient-on-staff assault. The themes that emerged in the data analysis included precursors to assault, intervention strategies, and staff and

organizational descriptors. The process map detailing themes and subthemes as related to the research questions is depicted in Figure 4.1.

Direct care staff and administrators identified patient illness, ineffective medication management, and environmental factors that could cause or escalate agitation and aggressive behavior. The two groups discussed intervention strategies to protect the safety of the patient and staff including therapeutic communication, seclusion and physical restraint, emergency medication issues, emergency response codes, and event reporting. Perceptions of administrative functions covered policy and procedure development, quality improvement activities and training. Staffing adequacy was discussed including experience, longevity, and gender mix. The personal characteristics of individual staff that work well to prevent or respond to aggression were identified as emotional intelligence, situational awareness, and the ability to develop a good rapport with patients.

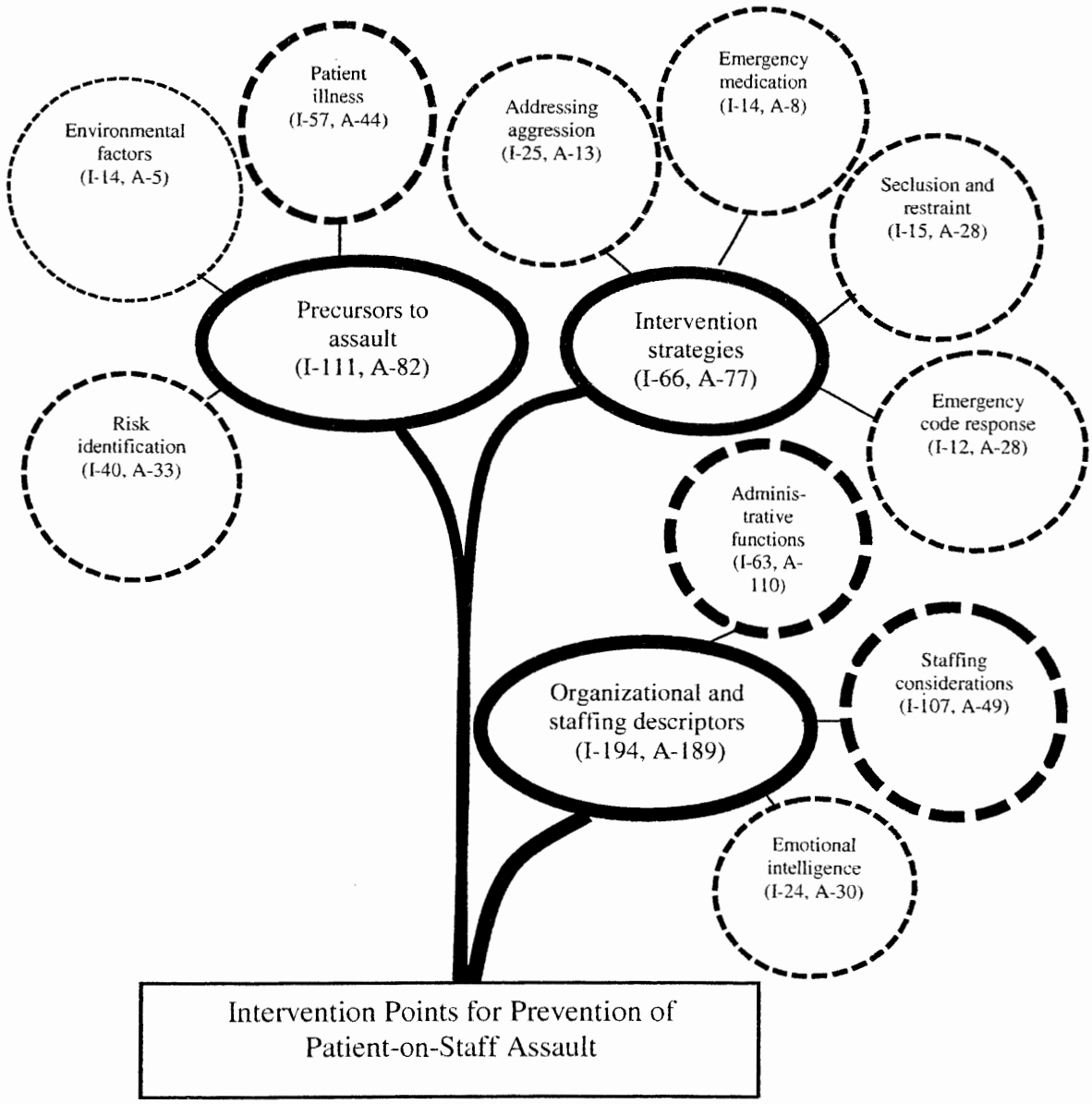

Figure 4.1. Intervention Points for Patient-on-Staff Assault.
Note: Themes are depicted with an oval shape, subthemes are depicted in circles, and the heaviness of the lines represents the frequency of themes and subthemes discussed by participants.

CHAPTER V

SUMMARY OF THE STUDY

The purpose of the study was to describe how inpatient psychiatric healthcare providers and administrators perceived policies in place to prevent, address, and monitor assault. The high rate of patient-on-staff assault among healthcare workers, especially those in psychiatric specialties, was the background of the study. Interpretive description was the theoretical framework used to describe and explore how administrative functions such as policies, procedures and training affect the assault rate on direct care providers within the hospital, and how additional institutional efforts may be planned to prevent future assaults (Thorne, 2000). The information gained from the study may inform administrators and aid in development of programs for the clinical setting to improve patient and staff safety. This chapter provides a summary of the findings, a review of the findings in relation to the literature, conclusions, implications, and recommendations for further study.

Summary

A descriptive interpretive design was chosen to examine the perceptions of inpatient psychiatric personnel and administrators regarding institutional policies and procedures in place to prevent, address, and monitor assault. Consistent with descriptive

interpretation, the data were analyzed to identify clinically relevant solutions to the practice problem of patient-on-staff assault in the psychiatric specialty care setting. A purposive sample of seven direct care providers and seven administrators was recruited. All participants shared their perceptions in a semi-structured interview intended to explore the research question. The digitally recorded data were transcribed and analyzed according to the Giorgian method of qualitative data analysis. Data collection continued until a thick description of the process and issues had emerged and no new information was revealed. The participant's perceptions served as the basis for the descriptive interpretation.

The study population worked in four inpatient psychiatric settings in Harris County, Texas. The majority of participants were female (71%) and had worked in psychiatric healthcare specialty in excess of 10 years (79%). All participants had been assaulted by a patient at least once in their career (100%) and many had been assaulted within the past year (57%). The sample included direct care providers (n=7) and administrative leaders (n=7). The professions included RNs (n=11) and psychiatric technicians (n=3).

Three themes emerged in the participant's descriptions of processes and procedures associated with assault: precursors to assault, intervention strategies, and organizational and staffing descriptors. The research questions were posed to each group and the analysis of data found these themes to be supported by both groups. Descriptions

were examined within the context of policies to prevent and address aggressive behaviors and conclusions to improve clinical practice were promulgated.

Precursors to Assault

The study population described the nature of psychiatric illness and presenting signs and symptoms that may include agitation and aggression. Perceptions of the subjects were that prevention of aggression and violence on the patient care unit may not be completely preventable, but early recognition of precursors to assault were clinically relevant in halting the escalation of agitation and aggression to physical assault. Policies and procedures reviewed for patient care described an attempt to manage agitation and aggression before the situation progresses to a need for seclusion and restraint. Precursors were identified that would merit close monitoring or early intervention to prevent aggression included patients with psychiatric illness associated with agitation or aggression, history of physical aggression, ineffective medication management, signs of aggression, orders for restrictions, and special observation. Careful monitoring of peer interaction in the milieu and interaction students and visitors including family members are also important as these influences were identified by study participants as a potential catalyst for physical aggression.

Intervention Strategies

Participant's perceived early identification of risk as being essential to the prevention of escalation in aggressive behavior. Staff described a process to intervene early by administering PRN medication and allowing time for the medication to have a

therapeutic effect. Descriptions of assault included some patients who assault staff seemingly without warning while others exhibit early signs of aggression such as self-talk, pacing, making fists, and talking loudly. Patients with a history of violence were thought by participant's to be at greater risk of acting out with aggressive behaviors in subsequent admissions.

Study participant's described identification of agitation and aggression and the determination of need to address the aggression with a goal of protecting the patient from harming self or others. Therapeutic communication was used to try to verbally de-escalate the patient before moving to physical restraint, seclusion, and emergency medication. An emergency code was called to summon additional trained personnel to the unit to help as needed during the process of a physical restraint, emergency medication administration and, if needed, seclusion.

Organization and Staff Descriptors

Participants described their perceptions of the roles of administration. The groups of participants identified numerous roles including, development of policies and procedures, fostering a supportive work environment, planning data collection and analysis for the quality program, and providing education and training. Staffing adequacy was identified by direct care providers as being important for managing patients competently. Concerns relating to staffing included having enough staff with a mix of experience in psychiatric specialty care and longevity in the institution to maintain a safe milieu. Participants also identified the need to have a mix of male and female staff on the

unit to improve therapeutic communication and address privacy issues. The relationship between the nurse and physician was also described as being an important factor in addressing patient behaviors.

Administrative personnel emphasized data collection, analysis, and reporting as an important part of quality process improvement. Direct care staff were aware of quality programs and were able to reflect on changes in the work environment that had been set in place following data analysis and quality planning. Both groups were able to describe annual training but direct care providers were critical of the physical restraint portion of the training stating that the training was not realistic enough to be a valuable simulation.

Emotional intelligence of staff was described as important to both groups of participants in describing how the staff respond to patient aggression. Participants emphasized the importance of not taking patient behaviors personally or responding to patient aggression with similarly aggressive behavior. Situational awareness was also identified as important to know how to respond and defuse a situation with the use of therapeutic communication, distraction, or determining the cause of the aggression and removing it rather than progressing to a physical restraint. The staff's ability to establish a good rapport with patients was also described as protective from aggression. Participants reported that a patient is less likely to assault a staff person who has treated him or her well.

Discussion of Findings

Factors leading to assault described by participants were consistent with the literature on assault in an inpatient psychiatric center. Policies and procedures were reviewed that address the management of patient aggression and prepare the staff to manage aggression when it occurs, however, the policies addressed patient aggression from the perspective of patient safety and not an overarching plan for staff safety as described by OSHA in their guidelines for prevention of violence in a healthcare setting (US-OSHA, 2004).

Precursors to Assault

The nature of the patient's illness, medication management, restrictions, and environmental stressors were identified by study participants as factors leading to patient aggression. Participants described process changes that could improve response to these factors, but the sources of agitation and aggression were perceived as unchangeable. The description of patient factors from the literature were consistent with the study population including unpredictable and uncontrollable agitation and aggression due to mental disorders such as schizophrenia and delusional disorders as well as drug seeking behavior, and the presence of patients under the influence of illicit drugs (Barlow et al., 2000; Currid, 2008; Daffern, Mayer & Martin, 2006; Duxbury, 1999; Grassi et al., 2001; Kindy, Petersen, & Parkhurst, 2005). Study participant's descriptions differed from statements in the literature that violence is a part of the job as a psychiatric care provider by making a distinction that agitation and aggression is ever present in the work

environment; nevertheless, progression to assault can be prevented in most cases (Gacki-Smith et al., 2009; Nachreiner et al., 2007; Poster & Ryan, 1994).

Other environmental factors described by study participants included factors in the patient care milieu that could promote aggression including special observation, restrictions, students, and visitors. A policy from one institution described the intent of patient observations and restrictions as measures to improve patient and staff safety, but study participants described observations and restrictions as a possible cause of agitation and aggression due to symptoms of the patient's illness or because they created conflict between staff or peers. The literature showed that limit setting with patients such as smoking restrictions and decreased privacy or personal space for patients such as one-to-one precautions could increase aggression (Grassi, et al. 2001; Ilkiw-Lavalle & Grenyer, 2003; Owen et al., 1998).

Study participants identified the presence of students or visitors as a possible catalyst for increased agitation and aggression in patients. Other patients were also described as increasing these symptoms if there were patients on the unit who also displayed aggressive behavior or if the patient fixated on the other patient. Similarly, the literature identified patients and visitors as possible causes of aggression from interpersonal interactions; however, the presence of students was not found to be significant in causing aggression (Bowers et al., 2003; Ilkiw-Lavalle & Grenyer, 2003).

Participants described the ability to recognize risk, and then use PRN medications and therapeutic communication to manage patient aggression. Participants described

successful recognition of early signs of aggression and other occasions when they were unsuccessful in identifying early signs. The ability to recognize and intervene at the first of sign of aggression has been previously identified as a problem caused by poorly attentive care providers and inadequate staffing (Currid, 2008; Ilkiw-Lavalle & Grenyer, 2003).

Participant's identified the importance of communicating a patient's history of violence and factors that could lead to violence. This type of communication was described by the study population as informal communication from staff person to staff person or searching through patient medical record. The Institute of Medicine (IOM) (2011) issued meaningful use guidelines for EHRs to improve safety and quality of healthcare. While the guidelines are specific to psychiatric care, the IOM suggests that specialty settings identify meaningful use criteria that are clinically relevant to the setting. A violence risk profile within the EHR would be a meaningful clinical tool specific to a psychiatric specialty care setting.

Intervention Strategies

The study population described the process of using verbal de-escalation as the first line of action and then using physical restraint if patient aggression reaches a level where the patient is a danger to himself or others. Participants asserted that nearly all patient aggression could be stopped with therapeutic communication and PRN medications, but the progression to a physical intervention sometimes occurs. The two groups described the process for obtaining emergency orders; the nurse contacts the

physician for an emergency order for medication, restraint, and seclusion. Participants stated that the ability to provide emergency medication was sometimes delayed by physician response. Kindy, Petersen, and Parkhurst (2005) identified similar issues with physician involvement including ineffective medication management and slow response to emergency codes. Other literature has identified issues with physician support including problems with inadequate treatment plans, insufficient medication, and slow emergency response (Ilkiw-Lavalle & Grenyer, 2003; Poster & Ryan, 1994). The process described by study participants also included calling an emergency code to summon trained staff and, in some institutions, administration and security personnel. Participants criticized administration and security personnel for inconsistent response to emergency codes. US-OSHA recommendation support the need for consistent availability of trained security personnel to back up direct care providers as needed.

Organizational and Staff Descriptors

The administration's roles that supported the prevention of violence included fostering a supportive work environment, management of quality improvement, and development of education and training programs. Consistent with recommendations form the CDC (2002) and US-OSHA (2004), participants reported that administration analyzed data from event reports and patient care activities and reported results to the highest level of leadership and to the unit level staff. The literature showed the greatest variability in staff perceptions of safety, related to administration's quality activities for management of environmental conditions and development of safety policies and programs (Dejoy et

al., 2004; Thomas et al., 2005). OSHA recommends root cause analysis as a quality activity for assault events and a method for tracking and trending data (US-OSHA, 2004). Some study participants were able to identify activities related to quality improvement that demonstrated effectiveness of formal communication channels with leadership. Participants who were engaged in the process could speak positively about a new staffing initiative implemented by administration.

Training for therapeutic communication and physical restraint relates to an important function of direct care staff. All staff were trained at the time of hire and annually thereafter; the staff spoke positively about the verbal de-escalation portion of training; however the physical intervention portion of the training was criticized as not translating well to actual clinical practice. The need for adequate training was reported to be a causative factor for injury in the literature (Bensley et al., 1995). The physical intervention training should consider the fitness level and stature of employees.

The study participants' perceptions of staffing related to having an adequate number of staff and a good mix of staff with consideration of experience, skill level, and gender. The experience level of the staff was strongly linked by participants with the ability to recognize early signs of aggression and intervene early to resolve defuse patient agitation without physical aggression. Participants perceived the ability to manage early signs of aggression by male or female staff was patient specific and a mix of both genders should be available to meet the individual needs of patient communication to manage aggression and other privacy and cultural considerations. Studies from the literature cite

similar issues with inadequate staffing and indicate that direct care staff including nurses and psychiatric technicians, less experienced staff, and staff lacking training in the past year are at greater risk of assault (Chou et al.; 2002; Cunningham et al., 2003; Gacki-Smith et al., 2009). No significant difference was noted between gender and the ability to manage aggression (Daffern, Mayer, & Martin, 2006; Poster & Ryan; 1994). US-OSHA (2004) focused heavily on communication between administration and frontline employees, communication between employees, and training for sensitivity to cultural issues, including significance of gender, with patients.

Participants' perceived administration's role in support of the direct care staff was to provide an opportunity for their concerns to be heard and be addressed. An area of criticism for administration from direct care participants was the process of sending employees for treatment of injuries. The process focused on treatment of physical injuries, rapid return to work, and little emphasis on mental health care. Concerns from the literature regarding administrative response included reports of a lack of social support and insensitivity to assaulted workers by sending them back into the work environment with the same patient that assaulted them (Currid, 2008; Daffern, Mayer & Martin, 2006). Some direct care participants stated concern about reprisal if they spoke out about working conditions. Gacki-Smith et al. (2009) found similar results in which staff did not report injuries or safety concerns for fear of retaliation from administration. The US-OSHA (2004) recommends that healthcare facilities reduce violence through open communication between direct care staff and administration without concern for

reprisal, including participation of safety committees. The recommendations also suggested that administration provide medical care for assaulted staff including mental health services.

Emotional intelligence was viewed as a staff characteristic important to the ability to work with psychiatric patients. Staff described the value of being able to engage in potentially violent situations and not to take the patient's behavior personally. It was also important for the staff member to be able to assess the situation and the environment and develop a non-confrontational response. The ability to establish a rapport with patients was also considered to be a protective factor. Participants asserted that staff who have established rapport with patients are better able to assure patients that they want to help them calm down and not injure or fight with them. The concept of emotional intelligence has not been described in the literature. Participants who identified emotional intelligence as a protective factor were committed to the idea that framing the perception of the patient's symptoms in the context of illness, and not taking the behavior personally, was critical to managing aggression without physical intervention.

Conclusions

Based on the study's findings and the process and thematic elements associated with inpatient psychiatric personnel and administrator's perceptions of policies in place to prevent, address, and monitor assault, there are a number of conclusions were reached;

1. Many of the prevention strategies described in the guidance from OSHA for prevention of violence in healthcare personnel are in place but are focused on the patient.
2. Agitation and aggression are expected symptoms of some psychiatric illnesses; however, early and effective intervention could prevent the behavior from escalating to an emergency event requiring physical restraint, emergency medication, and seclusion.
3. Knowledge of risk factors for aggression could provide insight for attentive staff to monitor high-risk patients for early signs of violent behavior.
4. Early, effective use of PRN medications and verbal de-escalation are the most effective actions to address patient aggression without risking injury to patients and staff.
5. Staff injured while managing patient assault want their injuries and post-assault needs to be managed in a caring and compassionate manner.
6. Non-violent crisis intervention training is relevant and applicable to managing violent patients.
7. The data gathered following patient care events involving physical interventions have been used to make significant quality improvements in some clinical environments.

8. Employees with emotional intelligence were perceived as being able to form a rapport with patients and manage aggressive patients with intuitive solutions tailored to the situation and without regard for personal feelings.

Implications

Consistent with interpretive descriptive design, the implications of this study are planned to improve policies and processes related to preventing and addressing patient-on-staff assault. The implications are based on the analysis of inpatient psychiatric personnel and administrator's perceptions of the policies and processes currently in place and are as follows:

1. The need for an overarching organizational plan for prevention of physical aggression toward staff. The plan needs to address organization commitment, communication, data analysis, program planning and training.
2. The need for organizational strategies to identify opportunities for early intervention with potentially violent patients including:
    a. a partnership between administration, nurses, and physicians to implement routine medication regimens customized of the needs of a particular patient along with effective PRN medication orders and prompt response to emergency order requests.
    b. a revision to electronic medical records to include decision support for patient care activities specific to psychiatric care such as data collection for

observations and restrictions and an alert, similar to the flag for allergies, for a history of aggressive and violent behavior.

c. a collective review of data related to physical aggression during interaction with patient family and other visitors.

3. The need for operational pathways for improved response to aggression including:

   a. a more realistic type of training for physical intervention that considers the physical capabilities of the staff, continuous learning needs, and realistic patient aggression scenarios;

   b. implementation of the practice of calling an emergency code for all situations where physical intervention and emergency medications are used;

   c. development of a procedure for consistent assistance from administration and security personnel with formal roles to intervene during emergency codes;

   d. respective analysis of routine and PRN medication effectiveness for all patient's requiring emergency medication;

   e. evaluation of physician response times to calls from direct care staff for emergency medication orders;

f. consistent use of staff de-briefing following physical intervention and show of support events for process evaluation and improved situational awareness;

g. a pilot program of solutions to improve staff and patient rapport for assault reduction;

h. involvement of staff at the unit level in problem solving about unit specific data to obtain buy-in from staff and identify intuitive solutions for practice problems from the expert users; and

i. a review of procedural events in the follow-up care and treatment of injured employees to provide compassionate care beyond regulatory requirements and to include mental health support.

Recommendations for Further Study

The findings of this study support the need for further nursing research in the area of assault in the psychiatric health care setting. Recommendations include:

1. A comparison of assault rates and severity before and after implementation of an overarching plan for prevention of physical aggression among staff;
2. Exploration of best practices in medication management for routine medications, PRN medications for aggression, and emergency medications for effective management of aggression in patients with history of aggression, history of illicit drug use, drug seeking behavior and drug resistance;

3. Evaluation of an intuitive decision support tool in the electronic health record to assist nurses in pulling information relevant to assault to a single risk profile that would include a history of assault, history of seclusions and restraints, and history of emergency medication use;
4. A retrospective review of all assaults that seem to occur without warning to identify possible clues to address that behavior early and prevent this type of dangerous assault;
5. An evaluation of the concept of emotional intelligence to determine if persons who measure high on these scales have fewer physical interventions than other staff members.

REFERENCES

Agostinho, S. (2005). Naturalistic inquiry in e-learning research. *International Journal of Qualitative Methods, 4*(1), 1-13. Retrieved from: http://www.ualberta.ca/~iiqm/backissues/4_1/pdf/agostinho.pdf

American Psychiatric Association (2002). *Diagnostic and statistical manual of mental disorders DSM-IV-TR (4th ed.)*. Washington D.C.: American Psychiatric Association.

Barlow, K., Grenyer, B., & Ilkiw-Lavalle, O. (2000). Prevalence and precipitants of aggression in psychiatric inpatient units. *Australian and New Zealand Journal of Psychiatry, 34,* 967-974. doi: 10.1080/000486700271

Bensley, L., Nelson, N., Kaufman, J., Silverstein, B., Kalat, J., & Shields, J.W. (1997). Injuries due to assaults on psychiatric hospital employees in Washington State. *American Journal of Industrial Medicine, 31*, 92-99. doi: 10.1002/(SICI)1097-0274(199701)31:1<92::AID-AJIM14>3.0.CO;2-2

Bensley L., Nelson, N., Kaufman, J., Silverstein, B., & Shields, J.W. (1995). Patient and staff views of factors influencing assaults on psychiatric hospital employees. *Issues in Mental Health Nursing, 16*, 433-446.

Bowers, L., Jeffery, D, Simpson, A., Daly, C., Warren, J., & Nijman, H. (2006). Junior

staffing changes and the temporal ecology of adverse incidents in acute psychiatric wards. *Journal of Advanced Nursing, 57*(2), 153-160. doi: 10.1111/j.1365-2648.2006.04101.x

Bowers, L., Simpson, A., & Alexander, J. (2003). Patient-staff conflict: Results of a survey on acute psychiatric wards. *Social Psychiatry and Psychiatric Epidemiology, 38*, 402-408. doi: 10.1007/s00127-003-0648-x

Burns, N., & Grove, S. (1993). *The practice of nursing research: conduct, critique and utilization (2nd ed.).* Philadelphia, PA.: W.B.Saunders.

Calabro, K., & Baraniuk, S. (2003). Organizational factors related to safety in a psychiatric hospital: Employee perceptions. *AAOHN, 51*, 425-432. Retrieved from: http://ca3cx5qj7w.search.serialssolutions.com/OpenURL_local?sid=Entrez:PubMed&id=pmid:14596382

Centers for Disease Control and Prevention (CDC) National Institute for Occupational Safety and Health. (2002). Violence occupational hazards in hospitals (DHHS-NIOSH publication number 2002-101). Cincinnati, OH.: NIOSH Retrieved from: http://www.cdc.gov/niosh/docs/2002-101/

Chou, K. R., Lu, R. B., & Moa, W. C. (2002). Factors relevant to patient assaultive behavior and assault in acute inpatient psychiatric units in Taiwan. *Archives of*

Psychiatric Nursing, 26, 187-195. doi: http://dx.doi.org.ezproxyhost.library.tmc.edu/10.1053/apnu.2002.34394

Creswell, J. W. (1998). *Qualitative inquiry and research design choosing among the five traditions.* Thousand Oaks, CA.: Sage Publications.

Crow, S., Hartman, S., & Schlieder, E.G. (2002). Organizational culture: Its impact on employee relations and discipline in healthcare organizations. *The Healthcare Manager, 22*(2), 2-28. Retrieved from: http://ca3cx5qj7w.search.serialssolutions.com/OpenURL_local?sid=Entrez:PubMed&id=pmid:14959896

Cunningham, J., Connor, D. F., Miller, K., & Melloni, R. H. (2003). Staff survey results and characteristics that predict assault and injury to personnel working in mental health facilities. *Aggressive Behavior, 29*, 31-40. doi: 10.1002/ab.10027

Currid, T. J. (2008). The lived experience and meaning of stress in acute mental health nurses. *British Journal of Nursing, 17*(14), 880-884. Retrieved from: http://ca3cx5qj7w.search.serialssolutions.com/OpenURL_local?sid=Entrez:PubMed&id=pmid:18935838

Daffern, M., Mayer, M., & Martin, T. (2006). Staff gender ratio and aggression in a forensic psychiatric hospital. *International Journal of Mental Health Nursing, 15*(2), 93-99. doi: 10.1111/j.1447-0349.2006.00408.x

Dejoy, D. M., Schaffer, B. S., Wilson, M. G., Vandenberg, R. J., & Butts, M. M. (2004). Creating safer workplaces: Assessing the determinants and role of safety climate. *Journal of Safety Research, 35*, 81-90. doi: http://dx.doi.org.ezproxyhost.library.tmc.edu/10.1016/j.jsr.2003.09.018

Duhart, D. T. (2001). United States Department of Justice (2001) National crime victimization survey: Violence in the workplace, 1993-99 (NCJ publication no. 190076). Washington, D.C.: U.S. Department of Justice.

Duxbury, J. (1999). An exploratory account of registered nurses' experience of patient aggression in both mental health and general nursing settings. *Journal of Psychiatric and Mental Health Nursing, 6*, 107-114. doi: 10.1046/j.1365-2850.1999.620107.x

Duxbury, J., & Whittington, R. (2005). Causes and management of patient aggression and violence: Staff and patient perspectives. *Journal of Advanced Nursing, 50*, 469-478. doi: 10.1111/j.1365-2648.2005.03426.x

Flannery, R.B., Hanson, A., & Penk, W.E. (1995). Patients' threats: Expanded definition of assault. *General Hospital Psychiatry, 17*, 451-453. doi: http://dx.doi.org.ezproxyhost.library.tmc.edu/10.1016/0163-8343(95)00084-4

Flannery, R.B., & Walker, A.P. (2003). Safety skills of mental health care workers:

empirical evidence of a risk management strategy. *Psychiatric Quarterly, 74*, 1-10. doi: 10.1023/A:1021125804303

Gacki-Smith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2009). Violence against nurses in US emergency departments. *Journal of Nursing Administration, 39*(7-8), 340-349. doi: 10.1097/NNA.0b013e3181ae97db

Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H. E., Nachreiner, N. M., Giesser, M. S., ...Watt, G. D. (2004). An epidemiologic study of the magnitude and consequences of work related violence: the Minnesota Nurses' Study. *Occupational and Environmental Medicine, 61*, 495-503. doi:10.1136/oem2003007294

Giorgi, A. (1970). *Psychology as a Human Science*. New York, NY.: Harper & Row.

Giorgi, A. (1985). *Sketch of a psychological phenomenologic method.* In A. Giorgi (Ed.), Phenomenology and psychologic research. Pittsburg, PA.: University Press

Grassi, L., Peron, G. L., Marangoni, C., Zanchi, P., & Vanni, A. (2001). Characteristics of violent behaviour in acute psychiatric in-patients: A 5-year Italian study. *ACTA Psychiatrica Scandinavica, 104*, 273-279. doi: 10.1111/j.1600-0447.2001.00292.x

Hamadeh, R. R., Alaiwat, B. A., & Ansari, A.A. (2003). Assaults and non-patient induced injuries among psychiatric nursing staff in Bahrain. *Issues in Mental Health Nursing, 24*, 409-417. doi: 10.1080/01612840390212623

Holstein, J. A., & Gubrium, J. F. (2005). Interpretive practice. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.), (pp. 483-506) Thousand Oaks, CA: Sage.

Hospitals fined over failure to protect staff from violent patients. (2012, Alert). *Psychiatric News.* Retrieved from: http://alert.psychiatricnews.org/2012/03/hospitals-fined-over-failure-to-protect.html

Ilkiw-Lavalle, O. & Grenyer, B. F. S. (2003). Differences between patient and staff perceptions of aggression in mental health units. *Psychiatric Services, 54*, 389-393. doi: 10.1176/appi.ps.54.3.389

Institute of Medicine (IOM) of the National Academies (2011). *Clinical Practice Guidelines We Can Trust: Standards for developing trustworthy clinical practice guidelines (CPGs).* Retrieved from: http://www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Practice-Guidelines-We-Can-Trust/Clinical%20Practice%20Guidelines%202011%20Insert.pdf

Ito, H., Eisen, S. V., Sederer, L. I., Yamada, O., & Tachimori, H. (2001). Factors affecting psychiatric nurses' intention to leave their current job. *Psychiatric Service, 52,* 232-234. doi: 10.1176/appi.ps.52.2.232

Joint Commission E-dition (2011). Joint Commission Resources Accreditation Manager Plus. Retrieved from: http://amp.jcrinc.com

Kindy, D., Petersen, S., & Parkhurst, D. (2005). Perilous work: Nurses' work in psychiatric units with high risks of assault. *Archives of Psychiatric Nursing, 19*(4), 169-175. doi: http://dx.doi.org.ezproxyhost.library.tmc.edu/10.1016/j.apnu.2005.05.002

Lanza, M. L. & Kayne, H. L. (1995). Patient assault: A comparison of patient and staff perceptions. *Issues in Mental Health Nursing, 16*, 129-141.

Lincoln, Y. S. & Guba, E. G. (1985) *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Little, L. (1999). Risk factors for assaults on nursing staff: Child abuse and educational level. *Journal of Nursing Administration, 29*, 22-29. Retrieved from: http://ca3cx5qj7w.search.serialssolutions.com/OpenURL_local?sid=Entrez:PubMed&id=pmid:10608937

Love, C. C., & Morrison, E. (2003). American Academy of Nursing Expert Panel on violence policy recommendations on workplace violence. *Issues in Mental Health Nursing, 24,* 599-604. doi: 10.1080/01612840390219121

McKenna, B. G., Poole, S. J., Smith, N. A., Coverdale, J. H., & Gale, C.K. (2003). *A* survey of threats and violent behaviour by patients against registered nurses in

their first year of practice. *International Journal of Mental Health Nursing, 12,* 56-63. doi: 10.1046/j.1440-0979.2003.00269.x

McKinnon, B. & Cross, W. (2008). Occupational violence and assault in mental health nursing: A scoping project for a Victorian mental health service. *International Journal of Mental Health Nursing, 7, 1,* 9-17. doi: 10.1111/j.1447-0349.2007.00499.x

Mental Health Mental Retardation Authority of Harris County. (2012). *Crisis and emergency services.* Retrieved from: http://www.mhmraharris.org/Crisis-And-Emergency-Services.asp

Nachreiner, N. M., Gerberich, S. G., Ryan, A. D. & McGovern, P. M. (2007). *Minnesota Nurses' Study and perception of violence and the work environment, 45*(5), 672-678. doi:10.2486/indhealth.45.672

Owen, C., Tarantella, C., Jones, M., & Tennant, C. (1998). Violence and aggression in psychiatric units. *Psychiatric Services, 49,* 1452-1457.

Polit, D. F., Beck, C. T., & Hungler B. P. (2001). *Essentials of nursing research: Methods, appraisal, and utilization* (pp. 265, 270, 393). Philadelphia, PA: Lippincott Williams & Wilkens.

Polkinghorne, D. E. (1989). Phenomenologic research methods. In R.S. Valle & S. Halling (Eds.), *Existential Phenomenological Perspectives in Psychology*. New York, NY.: Plenum Press.

Poster, E. C., & Ryan, J. (1994). A multiregional study of nurses' beliefs and attitudes about work safety and patient assault. *Hospital and Community Psychiatry, 45,* 104-108. doi:10.1016/SO883-9417(96)80050-1

Richter, D., & Berger, K. (2006). Post-traumatic stress disorder following patient assaults among staff members of mental health hospitals: a prospective longitudinal study. *BMC Psychiatry 2006, 6*(15), doi: 10.1186/1471-244X-6-15

Rossberg, J. I., & Friis, S. (2003). Staff members' emotional reactions to aggressive and suicidal behavior of inpatients. *Psychiatric Services, 54*, 1388-1394. Retrieved from: http://ps.psychiatryonline.org.ezproxyhost.library.tmc.edu/article.aspx?volume=54&page=1388

Soares, J. F., Lawoko, S., & Nolan, P. (2000). The Nature, Extent and Determinants of Violence Against Psychiatric Personnel. *Work & Stress, 14*(2), 105-120. doi: 10.1192/apt.9.5.374

Speziale, H., & Carpenter, D. (2003). *Qualitative research in Nursing (3rd ed.).* Philadelphia, PA.: Lippincott.

St. George, S. (2010). Applied interpretation: a review of interpretive description by Sally Thorne. *The Qualitative Report, 15* (6) 1624-1628. Retrieved from: http:www.nova.edu/ssss/QR/QR15-6/stdeorge.pdf

Thomas, E. J., Sexton, J. B., Neilands, T. B., Frankel, A., & Helmreich, R. L. (2005). The effect of executive walk rounds on nurse safety climate attitudes: A randomized trial of clinical units. *BMC Health Services Research, 5* (28), 1-9. doi:10.1186/1472-6963-5-28

Thorne, S. (2008). *Interpretive Description.* Walnut Creek, CA.: Left Coast Press.

Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Interpretive description: a non-categorical alternative to developing nursing knowledge. *Research in Nursing & Health, 20* (2), 169-177. doi: 10.1002/(SICI)1098-240X(199704)20:2<169::AID-NUR9>3.0.CO;2-I

United States Census Bureau. (2003). *Population Profiles.* Retrieved from: http://2010.census.gov/news/press-kits/demographic-profiles.html

United States Department of Labor Bureau of Labor Statistics. (2006). Survey of Workplace Violence Prevention 2005. Retrieved from: http://www.bls.gov/iif/oshwc/osnr0026.pdf

United States Department of Labor Occupational Safety and Health Administration. (2004). *Guidelines for preventing workplace violence for healthcare and social*

service workers (OSHA 3148-01R 2004). Retrieved from: http://www.osha.gov/Publications/osha3148.pdf

United States Department of Labor Occupational Safety and Health Administration (US-OSHA). (2007). *OSHA renews alliance with American Association of Occupational Health Nurses.* Retrieved from http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=14229 .

Whittington, R. (2002). Attitudes toward patient aggression amongst mental health nurses in the 'zero tolerance' era: associations with burnout and length of experience. Journal of Clinical Nursing, 11, 819-825. doi: 10.1046/j.1365-2702.2002.00659.x

Wykes, T., & Whittington, R. (1998). Prevalence and predictors of early traumatic stress reactions in assaulted psychiatric nurses. *The Journal of Forensic Psychiatry, 9,* 643-653.

Zohar, D. (1980). Safety climate in industrial organizations: Theoretical and applied implications. *Journal of Applied Psychology, 65,* 96-102.

Zohar, D., & Luria, G. (2004). Climate as a social-cognitive construction of supervisory safety practices: Scripts as a proxy of behavior patterns. *Journal of Applied Psychology, 89,* 322-333. doi: 10.1037/0021-9010.89.2.322

Appendix A

Institutional Review Board Approval

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Office of Research
6700 Fannin Street
Houston, TX 77030-2343
713-794-2480 Fax 713-794-2488

June 28, 2012

Ms. Susan Parnell
College of Nursing
6700 Fannin Street
Houston, TX 77030

Dear Ms. Parnell:

Re: Inpatient Psychiatric Healthcare Worker and Administrator Perceptions of Workplace Interventions for Patient-on-Staff Assault (Protocol #: 17063)

Your application to the IRB has been reviewed and approved.

This approval lasts for one (1) year. The study may not continue after the approval period without additional IRB review and approval for continuation. It is your responsibility to assure that this study is not conducted beyond the expiration date.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. If you have any questions, please contact the TWU IRB.

The signed consent forms, as applicable, and final report must be filed with the Institutional Review Board in the Office of Research, IHS 10110, at the completion of the study.

Sincerely,

Carolyn Kelley, PT, DSc, NCS
Institutional Review Board - Houston

Appendix B

Informed Consent

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institute of Health Sciences-Houston Center
Nelda C. Stark College of Nursing
6700 Fannin St Houston TX [illegible]
713-794-2100 (voice) 713-794-2106 (fax)

CONSENT TO PARTICIPATE IN RESEARCH

Title: Inpatient Psychiatric Healthcare Worker and Administrator Perceptions of Workplace Interventions for Patient-on-Staff Assault

Investigator: Susan Parnell, BSN, MSN, MPH ..syparnell@texaschildrens.org 832-824-6980
Advisor: Rebecca Krepper, PhD, MBA.... ....rkrepper@mail.twu.edu 713-794-2106

Description of Research

The purpose of the research is to examine the perceptions of inpatient psychiatric personnel and administrators of inpatient psychiatric centers regarding institutional policies in place to prevent, address, and monitor workplace assault.

The data for the research will be gathered during an interview with you that will last approximately 55 to 70 minutes. Your interview will be digitally recorded to be transcribed at a later time by a professional transcriptionist. You may be re-contacted for clarification of information. If you are re-contracted, you will be asked to participate in a telephone call that should require approximately 10 minutes of your time

Potential Risks

Risks that may be associated with participation in the research include stress or anxiety and potential loss of confidentiality. The data will be managed confidentially by limiting access to the digital recording and transcribed interviews to the researcher, advisor, and professional transcriptionist. A secure file sharing system will be used for electronic data transfer. All printed study material will be maintained in a locked file in the Principal Investigator's office or on a password protected computer system. All voice recordings and identifiable participant information will be destroyed within 5 years of study completion.

Initials

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

There are no direct benefits to the participant for participation in this study; however participants will be offered a $20 gift card as a token of appreciation for the time and effort spent participating in the study.

You will be given a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research at 713 794-2480 or via e-mail at [illegible].

Participant Signature Date

*If you would like to know the results of this study tell us where you want them to be sent:

Email:
Or
Address:

Appendix C

Demographic Tool

Demographic Data Collection Tool

Gender

Male _____ Female _____

Age

Age in years _____

Role

Direct care provider _____ Administrator _____

Title of role _____

Length of employment in current role _____

Length of time in pysch/mental health specialty _____

Length of time with current employer _____

Work setting

Inpatient, acute care_____ Number of beds _____

Inpatient, chronic care _____ Number of beds _____

Healthcare team function

Direct patient care _____ Administration _____

Training on violence prevention

None _____

Non-violent crisis intervention within the past 12 months_____

Non-violent crisis intervention greater than 12 months ago_____

Other training related to prevention and management of patient violence_____

Frequency of assault

Within the past 12 months _____ Career total _____

Appendix D

Interview Guide

Inpatient Psychiatric Personnel

Interview Guide

What are the perceptions of inpatient psychiatric personnel regarding institutional policies in place to prevent address and monitor assault?

Sub-questions

In the context of the last assault you experienced, can you tell me about the events leading up to the assault?

How did the assault event end?

How was the assault event reported?

What are your expectations and/or suggestions for administration?

Probe questions

Please tell me more about that.

Describe the steps involved in that.

Tell me about the policies or procedures that describe that?

How did your training prepare you for that?

How did you feel about that?

Were you satisfied with that?

Does the assault that you have described differ from other assaults that you have experienced? How?

Is there anything you think I should know to understand the issues related to administrative issues regarding assault?

Administrative Personnel

Interview Guide

Research Question:

What are the perceptions of administrators regarding institutional policies in place to prevent address and monitor assault?

Sub-questions/statements:

In the context of the last assault that you managed, can you tell me about the events leading up to the assault?

How did the assault event end?

Please tell me about the process for reporting the event?

Tell me about policies, training or other safeguards in place to prevent, address or monitor assault?

Probe questions/statements:

Please tell me more about that.

Describe the steps involved in that.

Tell me about the policies or procedures that describe that?

How did your training prepare you for that?

How did you feel about that?

Were you satisfied with that?

Does the assault that you have described differ from other assaults that you have managed? How?

Is there anything you think I should know to understand the issues related to administrative issues regarding assault?