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Evaluating the Impact of a Modified AVADE Program on Health Care Workers' Confidence in Managing Patient Agitation

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**Evaluating the Impact of a Modified AVADE Program on Health Care Workers'
Confidence in Managing Patient Agitation**

Jessica Cappucci, DNP (c), MSN, RN

College of Nursing, University of Massachusetts, Amherst

Chair: Dr. Julia Ronconi, DNP, PMHNP

Site Mentor: Lisa Gouldthorpe, MSN, PMHN-BC, CARN

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Abstract

Background: In a one-year period (2021-2022) a Massachusetts hospital reported an increase from 283 assaults on staff to 360 assaults. Assaults on health care workers are associated with increased turnover rates, job dissatisfaction, emotional trauma, and incomplete tasks.

Purpose: The purpose of this DNP proposal was to evaluate the effectiveness of a multifaceted program intended to increase healthcare worker knowledge and confidence in managing agitation and violence among patients.

Methods: The project used a pre and post one-group design to evaluate an educational intervention, a modified AVADE program, using Thackery's (1987) Confidence in Coping with Patient Aggression, a 30-day post-intervention follow-up, and a post-violent incident follow-up. Quantitative data were analyzed using descriptive statistics and paired t-test, and qualitative data were analyzed using content analysis of an open response question on the post violence survey and the 30 day follow up survey.

Results: The modified AVADE program was found to increase confidence in coping with patient aggression. The education was reportedly used in practice within one month of taking the course and during violent events.

Discussion: An educational intervention that focuses on de-escalation, awareness, defense, proper restraint use, legal components, and case studies increased healthcare workers' confidence in coping with patient aggression. The educational intervention was found to be used in violent events, and in practice within one month of taking the course.

Conclusion: Providing education to healthcare workers in managing patient aggression increases their confidence in coping with patient aggression and offers tools they can use in practice.

Keywords: workplace violence, violence, healthcare, and de-escalation; education

Evaluating the Impact of a Modified AVADE Program on Health Care Workers' Confidence in Managing Patient Agitation

Introduction

The U.S. Bureau of Labor Statistics (2018) reports that the incidence rate for nonfatal occupational injuries resulting from intentional injuries by another person which involve days away from work was 10.4 per 10,000 among healthcare workers, compared to the incidence among all workers of 2.1 per 10,000. Workplace violence due to intentional injuries by another person in healthcare accounts for 2 percent of the nonfatal occupational injuries that require days away from work (U.S. Bureau of Labor Statistics, 2018). Nonfatal workplace injuries due to violence among healthcare workers account for 73 percent of all such workplace injuries (U.S. Bureau of Labor Statistics, 2018). The problem addressed in this DNP capstone proposal is lack of healthcare worker education and confidence in managing patient agitation and violence. It is important to address the problem of managing patient agitation to increase job satisfaction, improve patient outcomes, and reduce harm to healthcare workers. The purpose of the clinical project is to evaluate the effectiveness of a multifaceted program intended to decrease violence against healthcare workers by increasing healthcare worker knowledge and confidence in managing agitation and violence among patients.

In a one-year period (2021-2022) a Massachusetts hospital reported an increase from 283 assaults on staff to 360 assaults. In the United States it is estimated that 75% of healthcare workers report encountering workplace violence regularly (Otachi et al., 2022; Somani et al., 2020). Nurses who encounter workplace violence may experience anxiety, burnout, post-traumatic stress disorder, depression, lack of ability to perform patient care, and job dissatisfaction (Somani et al., 2020). In addition, workplace violence and assaults against

healthcare workers increases staff turnover rates, emotional trauma, job dissatisfaction, and reduces the ability to complete the job (Somani et al., 2020). In healthcare settings workplace violence accounts for 15% to 36% of annual nurse turnover rates (Otachi et al, 2022). Healthcare workers are at risk if they do not possess skills in identifying escalating situations, observing environmental safety, and utilizing de-escalation skills. Without these skills, healthcare workers cannot appropriately manage patient irritability or agitation in a health care setting and are at risk (D'Ettorre et al., 2018).

Background

Review of the Literature

Preventing Workplace Violence in Healthcare

The review of the literature focused on evidence-based practice in managing agitation in patients and interventions for reducing workplace violence against healthcare workers.

Methods Identified in the Literature

A search was conducted using the search terms *workplace violence, healthcare, healthcare workers, violence, de-escalation, violence, healthcare, and nurs**. The search parameters included peer-reviewed original research articles, or review articles, published between 2017 to 2022. Additionally, one article from 2011 was included because it included medication and restraints, which was not included in other studies. Electronic databases used for this literature review were Ovid (263) and Ebscohost (218) with a total of 481 records were screened. There were 428 articles excluded as they did not focus on workplace violence prevention, and 37 were excluded as they did not focus on healthcare workers or workplace violence prevention programs. Therefore, 16 studies were included in this review of the literature (Appendix A).

Findings Noted in the Literature

Interventions

All 16 studies addressed interventions to reduce the incidence of workplace violence, however, they differed in the specific interventions implemented. Interventions are included in Table 1.

Table 1:

Workplace violence interventions

Intervention	Authors
Cognitive rehearsal program (CRP), a culture of civility, respect, and engagement in the workplace program (CREW), a management of clinical aggression rapid emergency department intervention (MOCA-REDI), a train-the-trainers program	Somani et al. (2021)
Behavioral Emergency Response Team (BERT) program	Christensen et al. (2022)
Crisis Prevention Institute training	Badeaux et al. (2020)
Solution Focused Brief Therapy (SFBT), Simile Skills Secrets (SSS)	Baby et al. (2018)
De-escalation training	Adams et al. (2017); Arbury et al. (2017); Arnetz et al. (2017); Christensen et al. (2022); Ferrara et

	al. (2017); Hamblin et al. (2017); Lamont & Brunero, (2018); Thompson et al. (2022),
Trauma-informed care education	Thompson et al. (2022)
The ERASE mistreatment by patients	Wilkin et al. (2019)
STAMP warning signs for violence	Adams et al. (2017)
Staffing levels and workplace violence meetings	Arnetz et al. (2017); Asikainen et al. (2020)
Camera locations, bed alarms, security rounding, lighting in parking lots, panic buttons, timely consults	Arnetz et al. (2017)
Increased visibility	Morphet et al. (2018)
Active shooter	Arnetz et al. (2017); Hamblin et al. (2017)
Safety procedures	Arbury et al. (2017); Somani et al. (2021)
Reporting systems	Lamont & Brunero (2018); Somani et al. (2021)
Work support programs	Hamblin et al. (2017); Morphet et al. (2018); Somani et al. (2021); Wilkins et al. (2019)
Safety monitoring policies	Arbury et al. (2017); Arnetz et al. (2017); Hamblin et al. (2017)
Risk assessment	Adams et al. (2017); Arbury et al. (2017); Lamont & Brunero (2018); Morphet et al. (2018)
Unit walkthrough	Arnetz et al. (2017); Hamblin et al. (2017)
Simulation or mock code	Badeaux et al. (2020); Wong et al. (2018)
Breakaway and self-defense techniques	Badeaux et al. (2020); Lamont & Brunero (2018)

Restraints	Arbury et al. (2017); Kynoch et al. (2011)
Legal information	Arbury et al. (2017); Lamont & Brunero (2018)
Body language and positioning, high-risk areas, short and long-term options, safety huddle, recognizing escalating aggression	Lamont & Brunero (2018)
Team building	Arbury et al. (2017); Arnetz et al. (2017); Christensen et al. (2022); Morphet et al. (2018); Wong et al. (2018)
Medications	Kynoch et al. (2011)
Predatory violence education	Arbury et al. (2017)
Debriefings	Arnetz et al. (2017); Asikainen et al. (2020); Morphet et al. (2018).

Methods to Measure Effectiveness

Most of the researchers (10) used self-report questionnaires (Adams et al., 2017; Arnetz et al., 2017; Badeaux et al., 2020; Christensen et al., 2022; Ferrara et al., 2017; Hamblin et al., 2017; Lamont & Brunero, 2018; Thompson et al., 2022; Wilkins et al., 2019; Wong et al., 2018). These questionnaires included Thackrey's confidence in coping with patient aggression (Ferrara et al., 2017; Lamont & Brunero, 2018; Thompson et al., 2022), and the KidSIM questionnaire (Wong et al., 2018). In three studies both questionnaires and the number of violent incidences pre and post-intervention were compared (Arnetz et al., 2017; Christensen et al., 2022; Hamblin et al., 2017). The authors used a quasi-experimental approach with an intervention group of 21 hospital units and a control group of 20 hospital units, hospital workers from 10 different job

categories (611 males, 2,252 female) which were compared for the rate of workplace violence (Arnetz et al., 2017). Participants were from different jobs and departments throughout the hospital with the highest rates of participants in acute care and nursing (Arnetz et al., 2017).

Populations Studied

Study sample sizes across the 16 studies ranged from 57 participants to 443 participants from 41 different units (Adams et al., 2017; Badeaux et al., 2020; Christensen et al., 2022; Ferrara et al., 2017; Hamblin et al., 2017; Lamont & Brunero, 2018; Thompson et al., 2022; Wilkins et al., 2019; Wong et al., 2018). Authors who conducted reviews of the literature had sample sizes ranging from 12 to 39 research articles (Arbury et al., 2017; Asikainen et al., 2020; Baby et al., 2018; Kynoch et al., 2011; Morphet et al., 2018; Somani et al., 2021). Most studies reviewed did not consider race when examining workplace violence, this makes it difficult to identify racial disparities (Adams et al., 2017; Arbury et al., 2017; Asikainen et al., 2020; Baby et al., 2018; Badeaux et al., 2020; Ferrara et al., 2017; Hamblin et al., 2017; Kynoch et al., 2011; Lamont & Brunero, 2018; Morphet et al., 2018; Somani et al., 2021; Thompson et al., 2022; Wilkins et al., 2019; Wong et al., 2018). Few researchers considered gender (Adams et al., 2017; Christensen et al., 2022; Wong et al., 2018) and even fewer age (Adams et al., 2017; Christensen et al., 2022; Wong et al., 2018).

Study Designs

Several study designs were used across the 16 studies reviewed, including a quasi-experimental study (Lamont & Brunero, 2018), grounded theory (Wong et al., 2018), walkthrough methodology (Hamblin et al., 2017), transtheoretical model of change (Ferrara et al., 2017), a before and after study design (Adams et al., 2017; Wilkins et al., 2019), a quality improvement project (Christensen et al., 2022; Thompson et al., 2022), the plan-do-study-act

model (Arnetz et al., 2017), a systematic review (Arbury et al., 2017; Asikainen et al., 2020; Baby et al., 2018; Kynoch et al., 2011; Somani et al., 2020), a narrative review (Morphet et al., 2018), and the Joanna Briggs Institute practical application of clinical evidence combined with the Getting Research into practice tool was used (Badeaux et al., 2020). This shows that authors of the research on managing patient aggression and workplace violence have used several different study designs. This supports that the review of literature included multiple different types of research.

Research Findings

Workplace violence can be difficult to define due to there being multiple types of workplace violence including worker on worker, patient on worker, criminal, and personal relationship (Wolf et al., 2023). Workplace violence can also be multiple different forms such as bullying, verbal abuse, threat, physical abuse, sexual harassment, and sexual assault (Wolf et al., 2023). For the purpose of this project, we will define workplace violence as physical and verbal assaults. In contrast, educational programs only increase staff confidence in managing aggressive patients but do not decrease rates of workplace violence for nurses (Somani et al., 2021).

Educational programs related to communication, de-escalation, behavior management, warning signs, and team building were shown to improve health care workers' confidence in managing verbal and physical violence this was identified by questionnaires, pre and post-intervention surveys, safety rounds, hospital reports of aggressive patient encounters, and records of activation of the behavioral emergency response team (Baby et al., 2018; Badeaux et al., 2020; Christensen et al., 2022; Morphet et al., 2018), and increase staff confidence to manage patient aggression (Adams et al., 2017; Arbury et al., 2017; Arnetz et al., 2017; Asikainen et al., 2020; Baby et al.; 2018; Badeaux et al., 2020; Christensen et al., 2022; Ferrara et al., 2017;

Hamblin et al., 2017; Kynoch et al., 2011; Lamont & Brunero, 2018; Morphet et al., 2018; Somani et al. 2021; Thompson et al., 2022; Wilkins et al., 2019). De-escalation training decreased violent events by 9.1% in four inpatient units which was tracked by physical violence events per week over a six-week period and compared to per week violence rate prior to implementation of training (Badeaux et al., 2020). Authors of one study found that incident ratios of violent events were significantly lowered (Arnetz et al., 2017) while authors of another study found a decrease, but they did not conduct statistics on significance (Adams et al 2017). Authors of a metaanalysis found that factors which affect agitation and aggression are environment, management of care, and communication (Asikainen et al., 2020). Education trainings focused on de-escalation was found to statistical significantly increase the knowledge and use of verbal de-escalation (Adams et al., 2017). The de-escalation trainings were found to statistically significantly increase participants' confidence in coping with aggression (Ferrara et al., 2017; Lamont & Brunero, 2018; Thompson et al., 2022). Simulation and mock codes were found to enhanced confidence in managing an agitated patient which was identified by a using a pre and post questionnaire which was created by the researchers (Christensen et al., 2022) and qualitative interprofessional focus group (Wong et al., 2018). The reduction of violence related to educational programs showed mixed findings. Educational programs were shown to reduce violence (Baby et al., 2018; Badeaux et al., 2020; Christensen et al., 2022; Morphet et al., 2018).

Administrative interventions include work programs, practices, policies, and unit risk identification and lead to a significant reduction in violent incidences (Arnetz et al., 2017; Hamblin et al., 2017). Environmental interventions include changing camera locations, bed alarms, panic buttons installed, increasing security rounding, increasing visibility, lighting in parking lots, and staffing levels (Arnetz et al., 2017; Asikainen et al., 2020; Morphet et al.,

2018). Environmental factors lead to a reduction in violent incidences (Arnetz et al., 2017; Asikainen et al., 2020; Hamblin et al., 2017), including but not limited to a unit-based action plan (Hamblin et al., 2017), restraint management reduced harm to staff and patients (Arbury et al., 2017; Kynoch et al., 2011), risk assessment, teams for aggression management, increasing visibility, and post-incident support groups (Morphet et al., 2018). Debriefing was found to both reduce (Asikainen et al., 2020) and increase (Morphet et al., 2018) the incidence of patient violence. This could be due to the increased awareness of the importance of reporting (Morphet et al., 2018). A violence prevention action plan was found to be an effective intervention focused on environmental, administration, communication, and behavioral strategies (Arnetz et al., 2017; Asikainen et al., 2020).

The AVADE violence prevention program includes three facets related to workplace violence (Van Gorder, 2022). The first is de-escalation skills and awareness to reduce physical violence (Van Gorder, 2022). The second includes techniques and tools healthcare workers can use to protect themselves from physical violence (Van Gorder, 2022). The third includes how to escort individuals (Van Gorder, 2022).

Discussion

Workplace violence in healthcare is a risk to healthcare workers' safety and affects the ability to give patients safe and effective care (D'Ettoire et al., 2018). The purpose of this literature review is to identify educational interventions to increase healthcare workers confidence in coping with patient aggression and provide healthcare workers specific interventions to manage patient aggression. The results of this review of literature suggest that administrative factors to decrease workplace violence include staffing, timely consults, safety procedures, reporting systems, unit walk through, work support programs, workplace violence

meetings, and safety monitoring policies (Arnetz et al., 2017; Asikainen et al., 2020; Hamblin et al., 2017; Morphet et al., 2018; Somani et al., 2021). Environmental factors include camera locations, staffing levels, bed alarms, security rounding, panic buttons, increased visibility, and lighting in parking lots (Arnetz et al., 2017; Asikainen et al., 2020; Hamblin et al., 2017; Morphet et al., 2018). Educational factors include risk assessment, simulation or mock code, breakaway, self-defense techniques, de-escalation, predicting violence, restraints, legal information, body language, and positioning, high-risk areas, short and long-term options, recognizing escalating aggression, safety huddles, team building, medications, predatory violence, management and plan, and active shooter (Adams et al., 2017; Arbury et al., 2017; Arnetz et al., 2017; Asikainen et al., 2020; Baby et al.; 2018; Badeaux et al., 2020; Christensen et al., 2022; Ferrara et al., 2017; Hamblin et al., 2017; Kynoch et al., 2011; Lamont & Brunero, 2018; Morphet et al., 2018; Somani et al. 2021; Thompson et al., 2022; Wilkins et al., 2019; Wong et al., 2018). These educational factors were compared to the AVADE workplace violence prevention program which included the interventions of risk assessment, simulation or mock code, breakaway techniques, self-defense techniques, de-escalation, predicting violence, restraints, legal information, body language, and positioning, recognizing escalating aggression, team building, medications, predatory violence, and active shooter (Fowler, 2018). The AVADE program is an education training used in many facilities to address workplace violence through education (Christensen et al., 2023). Educational program interventions showed educational interventions had a reduction of violence (Baby et al., 2018; Badeaux et al., 2020; Christensen et al., 2022; Morphet et al., 2018), while other researchers showed educational interventions increased staff confidence in managing aggressive patients (Somani et al., 2021). Debriefings include discussing the incident and completing a patient, organizational, and unit debrief (Arnetz

et al., 2017; Asikainen et al., 2020; Morphet et al., 2018). Therefore, a solution to the problem of managing patient agitation and workplace violence against healthcare workers is to utilize these factors to implement a workplace violence prevention program to increase healthcare workers confidence in coping with patient agitation.

Limitations of this review include the use of only two databases and the possibility that studies were missed with the keywords chosen. There is also a lack of comprehensive educational materials offered to implement the training interventions, making these trainings difficult to reproduce. There was minimal research related to medications and restraint use to reduce workplace violence in healthcare. Implications for practice include the need for future research related to a specific program to decrease workplace violence across many acute care hospital units. Future research needs to focus on well-designed, controlled studies to investigate programs to reduce workplace violence against healthcare workers. This review of literature supports the need for a multifaceted workplace violence in healthcare prevention program. Solutions offered for a Doctor of Nursing Practice Project include using multifaceted workplace violence in healthcare prevention model including educational, environmental, behavioral, administrative, risk identification, and debriefs. The next steps include implementing a workplace violence prevention program in healthcare that combines administrative, education, environmental, and debrief factors (Appendix B).

Conclusions

This research supports that a reduction in workplace violence in healthcare is significantly associated with educational, environmental, behavioral, administrative, and debrief factors. Combining interventions identified in these categories can improve healthcare workers' safety and reduce the incidence of violence. The take-home message of this literature review is

that a multifaceted program that encompasses the multivariable aspects of violence against healthcare workers is needed to reduce workplace violence (Appendix B).

Theoretical Framework

The Plan-Do-Study-Act evidence-based practice model was used for this project proposal (Appendix C). This evidence-based practice model is used in quality improvement projects and improves systems through planning, implementing, analyzing, and modifying (Gorenflo & Moran, 2010). This model can be used to plan a program for workplace violence prevention, implement that plan, analyze the data, and modify the workplace violence prevention program as needed.

Objectives and Expected Outcomes

The overall goal/purpose of this DNP proposal is to evaluate the effectiveness of a multifaceted program, modified AVADE (Fowler, 2018) in increasing confidence in coping with patient aggression by increasing healthcare worker knowledge and skills in managing agitation and violence among patients. AVADE is an acronym for Awareness, Vigilance, Avoidance, Defense, and Escape (Van Gorder, 2022). The Modified AVADE program also includes proper restraint use, legal components, and case studies. The evaluation of an existing program is important to confirm its efficacy in improving staff confidence in managing aggression in the workplace, and skills being utilized in practice. This evaluation of the AVADE program is supported by the literature review because the AVADE program includes many of the components found to increase healthcare workers confidence in coping with patient aggression and reducing workplace violence. The AVADE program was chosen for this project because it is a popular workplace violence prevention program (Christensen et al., 2023) and it is currently being offered at the project site.

Table 2*Project Goals, Objectives, and Outcomes*

Goal/Purpose	Objectives	Outcomes	Measurements
To evaluate the effectiveness of a multifaceted program intended to decrease violence against healthcare workers by increasing healthcare worker knowledge and confidence in managing agitation and violence among patients.	<ol style="list-style-type: none"> 1. Offer a two-tiered modified AVADE education to all staff members: <ul style="list-style-type: none"> ○ Tier 3 for medical units consisting of 3.5 hours of education. ○ Tier 4 for the emergency and psychiatric departments with 4 hours of education. 2. Measure knowledge and confidence before and after intervention using a pre and post questionnaire to evaluate change in knowledge and confidence in managing agitation and violence among patients. 3. Healthcare staff will report using new knowledge to manage agitation among patients' post-intervention. 	<ol style="list-style-type: none"> 1. 90% of staff who are eligible to attend will attend education sessions. 2. 90% of participants will show an increase in knowledge and confidence in managing agitation and violence among patients. 3. Thirty days post-education, participants will report finding education useful to decrease escalating events and manage violence. 	<ol style="list-style-type: none"> 1. Percentage of staff who attend the training sessions will be obtained. 2. Pre/post assessment for knowledge-based assessment: Thackrey's (1987) Confidence in Coping with Patient Aggression Instrument (CCPAI). 3. 30-day post-education follow-up email (Appendix D) and a google forms questionnaire. (Appendix E).

4. Healthcare staff will report using new knowledge to manage agitation among patients' post-intervention.	4. Participants involved in an assault event within 30 days of the intervention, will report using learned skills from the AVADE education.	4. Post violence incident follow-up email (Appendix F) and Questionnaire (Appendix G).
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Methods

This project used a pre and post one-group design to evaluate an educational intervention. The educational intervention is a modified AVADE program (Fowler, 2018). The modified AVADE training program started in January 2023. To obtain data for this project a pre and post-assessment using Thackery's (1987) Confidence in Coping with Patient Aggression was completed by participants before and after the class. A 30-day post-class follow-up questionnaire was used to determine if participants used the training in practice, and if they found it helpful. Similarly, a post-violence incident follow-up questionnaire was used to determine if the training was useful during a violent event.

Project Site and Population

This DNP project was instituted at a Massachusetts Hospital. This facility has 413 patient beds with 120 inpatient psychiatric beds, 212 inpatient medical beds, a 65-bed emergency department, and a 16-bed acute mental health unit. The community served includes individuals from various cultural and ethnic backgrounds living on the north shore of Massachusetts. This Massachusetts hospital offers a broad range of health care, including medical-surgical, intensive care, cardiac, emergency, child psychiatry, adolescent psychiatry, adult psychiatry, and geriatric

psychiatry. The hospital also includes over 71 specialty departments. The current stakeholders include the 4,000 employees who work at the hospital and depend on a safe work environment.

The hospital is organized with various individuals of leadership in senior management, medical leadership, department chairs, and vice chairs. For each unit, there is a nursing director, clinical leaders, charge nurses, nurses, and support staff. Individuals working within the psychiatric inpatient care units are required to take the workplace violence training. Individuals working in other inpatient departments were encouraged to take the workplace violence prevention training. The modified AVADE program is required for new hire staff and an annual workplace violence training for inpatient psychiatric and emergency department healthcare staff, as well as an optional but highly encouraged training for other inpatient departments. In 2023 this Massachusetts hospital inpatient medical units reported 76 completed physical assaults, 62 attempted assaults, 80 threats, and 199 counts of verbal abuse. The inpatient psychiatric units and emergency department included 317 completed physical assaults, 141 attempted assaults, 150 threats, and 225 counts of verbal abuse. Recruitment for the class for these medical inpatient departments was done through discussions with unit directors, promotional videos throughout the hospital, and email bulletins. The number of healthcare staff includes nurses, clinicians, nursing assistants, patient care technicians, mental health counselors, and mental health workers. This Massachusetts hospital supported this research (Appendix H). Inclusion criteria for participation in the training were health professionals with direct patient care roles. Exclusion criteria included hospital staff who do not provide direct patient care.

Intervention

The AVADE program is centered around the key elements of awareness, vigilance, avoidance, defense, and escape (Personal Safety Training, Inc., n.d.). The tier 4 program is a

four-hour in-person training for psychiatric and emergency department staff. This includes components of the AVADE training with the addition of restraint education, hands-on restraint training, and legal aspects of self-defense and restraint use. The training uses scenarios and group discussions. Restraint training for tier 4 includes the use of soft restraints, hard restraints, and the restraint chair. The tier 3 training is a three-hour training for healthcare workers in all other inpatient patient care departments. The modified AVADE training focuses on the core components of the AVADE training which are Awareness, Vigilance, Avoidance, Defense, and Escape with the addition of restraint use, case studies, and education on legal aspects of self-defense and restraints. Restraint training is focused on soft and hard restraints. Both tiers focus on awareness of escalating behaviors, avoidance of violence, self-defense, and escape principles. Tier 4 includes more advanced self-defense skills.

Measurement

In order to measure the outcomes of this DNP Project, the following questionnaires and instruments were used:

- 1) Thackrey's (1987) Confidence in Coping with Patient Aggression Instrument (CCPAI) is a ten-question, 11-point Likert scale ranging from 1 low confidence to 11 high confidence. Cronbach's Alpha of 0.92 has been reported in previous research (Thackrey, 1987). See Appendix I.
- 2) 30-day post-education follow-up questionnaire which included three yes or no style questions, one select all that apply, and one open-ended question (Appendix E).

Reliability has not been determined for this tool as it was created specifically for this project.

- 3) Post-violence event questionnaire included three yes or no style questions, one select all that apply question, and one open-ended question (Appendix G). Reliability for this questionnaire has not been determined for this tool as it was created specifically for this project.

Implementation/Data Collection Procedures

This is a required training at the Massachusetts hospital for all inpatient psychiatric health care workers. New hires in the psychiatric department are automatically enrolled in this training. The training is highly encouraged for the emergency department and inpatient departments within the hospital. The training is an in-person training consisting of four hours for tier 4, and three hours for tier 3. Distribution of the pre and post-intervention questionnaires (Appendix I), to evaluate the training, occurred just before and after the training. A 30-day follow-up email (Appendix D) with an attached questionnaire (Appendix E) was sent via email to participants using the class attendance sheets from 30 days prior. Additionally, a post-violence incidence follow-up email (Appendix F) with an attached questionnaire (Appendix G) was sent to participants involved in a violent incident. These participants were identified by reviewing the safety events for the institution. Data was collected and entered into Excel which includes the 30-day follow-up, post-incident follow-up, and pre and post-questionnaire scores. Demographic data was also entered into Excel.

Data Analysis

Descriptive statistics were used to calculate the mean, median, mode, standard deviation, and range for variables for questionnaires. Descriptive statistics were used to analyze the demographics of the people who attended the educational sessions. Demographic data includes gender, age, department, and job role. A paired t-test was used to compare the means of pre and

post-intervention questionnaire scores. Qualitative content analysis was used for the open-ended responses in the post-violence follow-up questionnaire (Appendix G) and the 30-day follow-up questionnaire (Appendix E), content analysis was used to identify common terms, themes, and patterns.

Ethical Considerations/Protection of Human Subjects

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) determination was obtained prior to initiating the DNP Project. Also, determination from the Massachusetts Hospital Internal Review Board (IRB) determination was obtained prior to initiating the DNP Project. All participants listed in the safety event reporting were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which protects the health information of patients (Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013). Participants were given a written consent before initiation of data collection; they were informed they can withdraw at any time. Individual identification numbers were used for participants pre and post-surveys. The list of class participants who participated in the research and their identifying numbers was kept in locked filing cabinets within an office, only accessible to the project coordinators. Participant emails were kept on a password-protected computer. To prevent unauthorized access to electronic files that contained identifiable information the files were password-protected with only the project coordinator having access to the password.

Timeline

Starting September 15, 2023, the instructors of the AVADE course got an overview of the research project. This overview included the study design, course questionnaires, and goals. Data was presented related to the literature review, the project design, and the data collection

process. Data collection information included the pre and post survey, the 30 day follow up, and the post violence follow up. It was explained to the instructed the importance of distributing the pre and post-assessment before and after the class. The primary researcher was the individual distributing the pre and post-assessment. The educational intervention was offered weekly and data collection started on October 1, 2023, along with the immediate pre and post-data collection (Appendix K). Starting October 15, 2023, the post-violent event was followed up with an email to all staff involved in safety events involving violence. Starting November 1, the 30-day follow-up assessment was emailed to all attendees of the classes. Each week the data were entered into an Excel file. The class data collection and post-violence assessment continued until December 31, 2023. The 30-day follow-up data were collected until January 31, 2024. This was followed by data analysis and project finalization. In May 2024 the results will be presented to the hospital.

Cost-Benefit Analysis

Workplace violence at this Massachusetts hospital resulted in 637 lost workdays and 39 restricted workdays in 2023. Workplace assaults resulted in a cost of \$177,720.64 due to employee injuries. The modified AVADE program is a job requirement for inpatient psychiatric staff and is highly encouraged for all other inpatient units. The AVADE course was purchased by this Massachusetts hospital, and classes are conducted multiple times a month. Therefore the classes do not come at an additional cost for this research project. This project cost is minimal and includes the additional cost of paper for the pre and post-assessment evaluations (Appendix L). The benefits of this project are to identify the effect of a workplace violence prevention program and modify the program as needed to protect healthcare workers and improve patient care.

Results

Demographics

This project took place at a community academic hospital, with a total of 130 participants in the AVADE modified course, 29 individuals completed the 30-day follow-up, and 7 completed the post-violence survey. Of the 130 participants that participated in the modified AVADE course, 96 were female, 33 were male, and 1 identified as other. The age group of participants were 18-20 years old (n=1), 20-29 years old (n=36), 30-39 years old (n=39), 40-49 years old (n=23), 50-59 years old (n=16), 60-69 years old (n=11), and 70 or greater (n=4). Race and ethnicity were not collected from the study participants as it was not part of the participant data in the internal class registration or included on the survey questions. This quality improvement project included participants from across the hospital in varying job roles and departments. The participants in this project who completed the pre and post survey represented 13 job roles from 20 different departments. The departments of participants included inpatient psychiatry, float pool, three inpatient medical-surgical units, medical telemetry, two inpatient cardiology units, emergency department, emergency department mental health unit, surgical care, greeter department, students, security department, birthplace, nursing administrators, and patient observer department. Job titles for healthcare worker participants included mental health specialists, mental health workers, registered nurses, travel nurses, patient care associates, travel patient care associates, security officer, patient ambassador, patient observer, case manager, students, nursing director, and clerical. Of these participants, 59.2% (n= 77) had taken the AVADE course prior, but not the modified AVADE course, and 40.8% (n=53) had never taken the AVADE course. Of these participants, 37.7% (n=49) took the tier 3 class and 62.3% (n=81) took the tier 4 class (*Table 3*).

Table 3*Demographic Characteristics of Class Participants that participated in the study.*

Sample Characteristics	Frequency	Percentage (%)
Gender		
Female	96	73.8%
Male	33	25.4%
Other	1	0.8%
Age Group		
18-20	1	0.8%
20-29	36	27.7%
30-39	39	30%
40-49	23	17.7%
50-59	16	12.3%
60-69	11	8.5%
70+	4	3.1%
Department		
Adult Psychiatry	28	21.5%
Emergency Department	15	11.5%
Pediatric Psychiatry	14	10.8%
Senior Psychiatry	11	8.5%
Float Pool	9	6.9%
Unit 1 Cardiology	8	6.2%
Surgical Care	6	4.6%

Unit 1 Medical Surgical	6	4.6%
Unit 2 Cardiology	6	4.6%
Unit 2 Medical Surgical	5	3.8%
ED Mental Health Unit	4	3.1%
Unit 3 Medical Surgical	4	3.1%
Birthplace	4	3.1%
Nurse Admin supervisor	3	2.3%
Security	2	1.5%
Behavioral Health Float Pool	1	0.8%
Patient observer department	1	0.8%
Greeter program	1	0.8%
Student	1	0.8%
Medical Telemetry	1	0.8%

Job Title

Mental health specialist	25	19.2%
Mental health worker	3	2.3%
Registered Nurse	57	43.8%
Travel Nurse	21	16.2%
Patient care associate	5	3.8%
Patient care associate traveler	3	2.3%
Security officer	2	1.5%
Patient ambassador	1	0.8%
Patient observer	1	0.8%

Case manager	7	5.4%
Student	2	1.5%
Nurse director	2	1.5%
Clerical	1	0.8%
Prior AVADE Training		
No	77	59.2%
Yes	53	40.8%
Tier		
Tier 3	49	37.7%
Tier 4	81	62.3%

Survey Results

The results of this quality improvement project show that mean scores for Thackery's confidence in coping with patient aggression increased from pre-survey to post-survey (*Figure 1*). The p-value is less than 0.5 so we can reject the null hypothesis that there is no significance between confidence in confidence in coping with patient aggression before and after taking the modified AVADE course. This means that the modified AVADE program does increase confidence in coping with patient aggression.

First-time participants were compared to those who took the AVADE course prior. Both first-time participants and those who had previously taken the AVADE course had p-value of less than 0.5, rejecting the null hypothesis. This means that the modified AVADE program does increase confidence in coping with patient aggression for both first-time class participants and those who took the AVADE course prior.

For first-time participants the correlation coefficient is 0.655 which is considered moderate, suggesting a positive relationship between the scores of the pre and post-survey. For participants who took the AVADE class previously the correlation coefficient is 0.918 which is considered high, indicating a very strong positive relationship between scores of the pre and post-survey. Overall, the correlation coefficient was 0.731 which indicates a strong positive relationship between pre and post-survey total scores. This indicates that for both groups, new class participants and those who have taken the non-modified AVADE program previously, the modified AVADE training was effective in increasing confidence in coping with patient aggression (*Table 4*).

Figure 1

Pre and Post Assessment Scores on Thackery's Confidence in coping with patient aggression

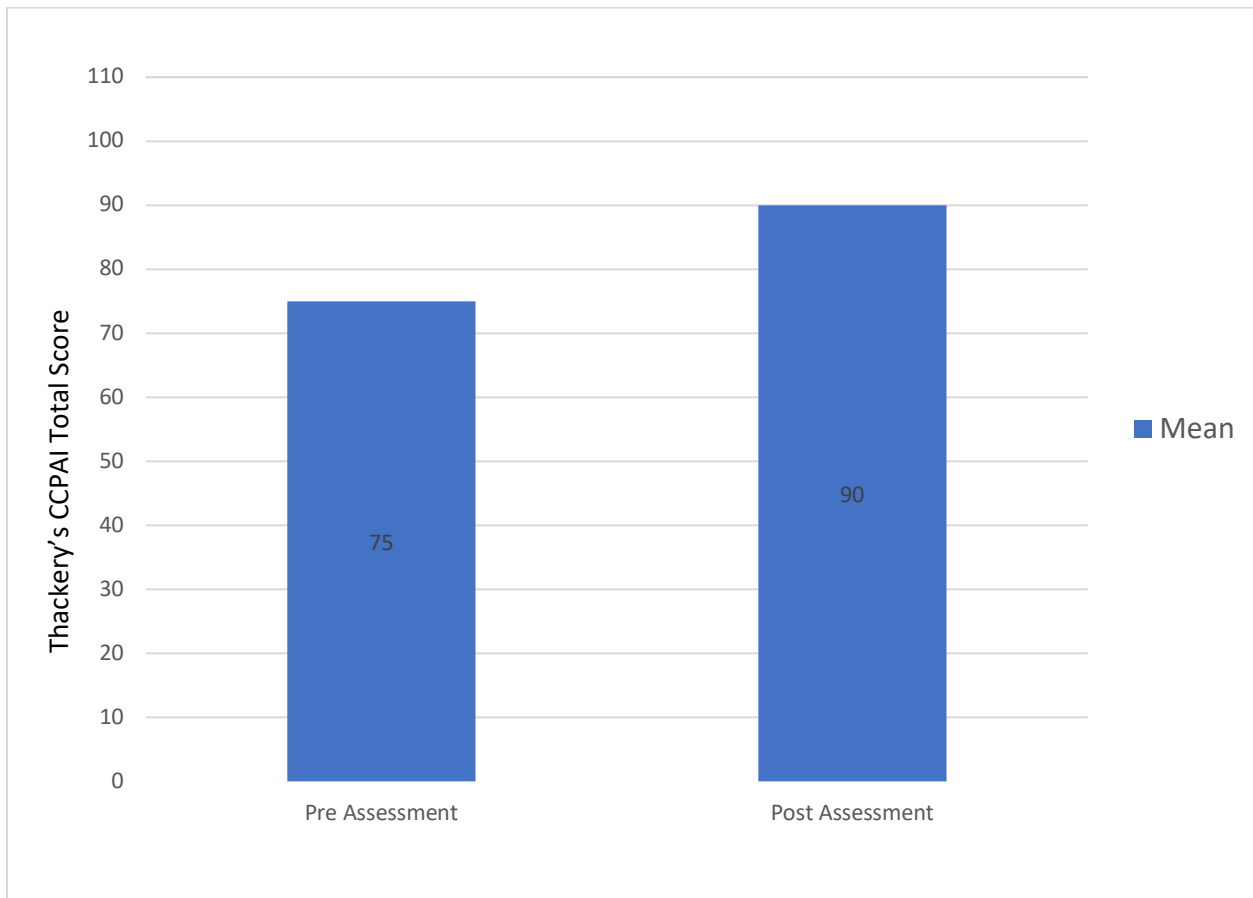


Table 4*Overall Assessment Scores on Thackery's Confidence in coping with patient aggression (CCPAI)*

Measure	Group	Pre- training mean (SD)	Post- training mean (SD)	t-value	df	Correlation	P-value
CCPAI	First-time	63.84	87.84	-13.271	76	0.655	<0.001
Score	AVADE participants	(20.99)	(14.06)				
	Repeat	81.36	91.08	-9.143	52	0.918	<0.001
	AVADE Participants	(18.5)	(14.54)				
	Overall	70.99	89.16	-13.906	129	0.731	<0.001
		(21.72)	(14.29)				

Analyzing ten questions within Thackery's confidence in coping with patient aggression, p-value for each question is less than 0.5. Therefore, we can reject the null hypothesis. This means that the modified AVADE program does increase comfort in working with patient aggression, increases the level of training for handling psychological aggression, increases perceived ability to intervene physically with an aggressive patient, increases self-assurance when in the presence of an aggressive patient, increases ability to intervene psychologically with an aggressive patient, increases present level of training for handling physical aggression, increases perceived safety around an aggressive patient, increases perceived effectiveness of the

techniques known for dealing with aggression, increases the ability to meet the needs of aggressive patients, and protect oneself physically from an aggressive patients (*Table 5*).

Table 5

Assessment Scores for each question of Thackrey's CCPAI by Previous Exposure to AVADE

Training

Measure	Group	Pre- training mean (SD)	Post- training mean (SD)	Correlation	P-value
1. How comfortable are you in working with an aggressive patient?	First-time participants	6.9 (2.16)	8.71 (1.53)	0.602	<0.001
	Participants who took the AVADE (unmodified) course previously	8.23 (2.03)	9.17 (1.54)	0.822	<0.001
	Overall	7.45 (2.20)	8.90 (1.54)	0.693	<0.001
2. How good is your present level of training for handling	First-time participants	6.34 (2.41)	8.70 (1.54)	0.548	<0.001

psychological

aggression?

Participants	8.36 (1.73)	9.2 (1.43)	0.806	<0.001
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who took the

AVADE

(unmodified)

course

previously

Overall	7.16 (2.38)	8.90 (1.51)	0.628	<0.001
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3. How able are you

to intervene

physically with an

aggressive patient?

First-time	6.14 (2.64)	8.74 (1	0.542	<0.001
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participants

.51)

Participants	7.79 (2.36)	8.87 (1.64)	0.921	<0.001
--------------	-------------	-------------	-------	--------

who took the

AVADE

(unmodified)

course

previously

Overall	6.82 (2.68)	8.80 (1.56)	0.675	<0.001
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4. How self-assured

do you feel in the

First-time	6.47 (2.22)	8.73 (1.52)	0.586	<0.001
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participants

presence of an
aggressive patient?

Participants	8.13 (2.02)	9.06 (1.54)	0.871	<0.001
--------------	-------------	-------------	-------	--------

who took the
AVADE
(unmodified)

course

previously

Overall	7.15 (2.82)	8.86 (1.53)	0.683	<0.001
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5. How able are you

First-time	6.77 (2.04)	8.81 (1.50)	0.618	<0.001
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to intervene

participants

psychologically with

an aggressive patient?

Participants	8.47 (1.97)	9.28 (1.45)	0.777	<0.001
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who took the
AVADE

(unmodified)

course

previously

Overall	7.46 (2.18)	9.00 (1.49)	0.680	<0.001
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6. How good is your

First-time	6.10 (2.50)	8.88 (1.54)	0.619	<0.001
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present level of

participants

training for handling

physical aggression?

Participants	8.11 (2.0)	9.11 (1.5)	0.810	<0.001
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who took the

AVADE

(unmodified)

course

previously

Overall	6.92 (2.51)	8.98 (1.52)	0.654	<0.001
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7. How safe do you

feel around an

aggressive patient?

Participants	7.72 (2.22)	8.93 (1.63)	0.898	<0.001
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who took the

AVADE

(unmodified)

course

previously

Overall	6.78 (2.41)	8.68 (1.67)	0.774	<0.001
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8. How effective are

the techniques that

you know for dealing

with aggression?

First-time	6.25 (2.32)	8.95 (1.50)	0.498	<0.001
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participants

	Participants	8.15 (1.92)	9.23 (1.53)	0.836	<0.001
	who took the				
	AVADE				
	(unmodified)				
	course				
	previously				
	Overall	7.02 (2.35)	9.06 (1.51)	0.601	<0.001
9. How able are you	First-time	6.32 (2.19)	8.82 (1.48)	0.466	<0.001
to meet the needs of	participants				
an aggressive patient?					
	Participants	8.28 (1.85)	9.13 (1.57)	0.846	<0.001
	who took the				
	AVADE				
	(unmodified)				
	course				
	previously				
	Overall	7.12 (2.27)	8.95 (1.52)	0.590	<0.001
10. How able are you	First-time	6.43 (2.44)	9.00 (1.44)	0.579	
to protect yourself	participants				
physically from an					
aggressive patient?					
	Participants	8.11 (2.20)	9.08 (1.65)	0.845	<0.001
	who took the				

AVADE				
(unmodified)				
course				
previously				
Overall	7.12 (2.48)	9.03 (1.52)	0.653	<0.001

There were 29 participants completed the 30-day follow-up survey. Of these participants, 93% reported they found the training helpful in practice and 86% were using the training in practice at some point one month after taking the modified AVADE course. Participants reported learning the following concepts in the AVADE class: body language, self-awareness, de-escalation, environmental awareness, intuition, positioning, own the door, situational awareness, emotional awareness, signs/symptoms of anger, restraint education, understanding the assault cycle, escape planning, understanding violence and who commits it, escape planning, defensive strikes, defensive blocks, and other (*Table 6*).

Table 6

30-day Post Class Follow-up Questionnaire Results

Survey Question Responses	Yes		No		N/A	
	n	%	n	%	n	%
1. Used training in practice?	25	86%	4	14%	0	0%
2. Found training helpful	27	93%	1	3.5%	1	3.5%
3. Techniques used in practice						
Body language	22					
Self-awareness	21					

De-escalation	20
Environmental awareness	17
Your Intuition	17
Proper positioning	17
Own the door	16
Situational awareness	16
Emotional awareness	16
Signs/symptoms of anger	16
Restraint education	13
Understanding the assault cycle	13
Escape planning	12
Understanding violence and who commits it	11
Defensive strikes	8
Defensive Blocks	8
Other	3
None selected	2

In the post-violence event survey, all 7 individuals surveyed had taken the modified AVADE course. Six of the seven individuals used some aspect of the AVADE training in the violent event. One participant left a comment in the comment section of the survey which discussed using body language and blocking techniques. The seven participants reported that

techniques used in the violent event included de-escalation, body language, signs and symptoms of anger, environmental awareness, self-awareness, situational awareness, emotional awareness, intuition, understanding the assault cycle, understanding violence and who commits violence, defensive blocks, proper positioning, escape planning, and restraint education (*Table 7*).

Table 7

Post Violence Incidence Follow-up Questionnaire Results

Question	Yes		No		N/A	
	n	%	n	%	n	%
1. Have you taken the modified AVADE training course?	7	100%	0	0%	0	0%
2. Did you use any aspect of the modified AVADE training while being involved with the violent/agitated patient in this safety event?	6	86%	1	14%	0	0%
3. Was the training helpful?	6	86%	1	14%	0	0%
4. Techniques used in the violent event						
Body language	4					
Self-awareness	4					
De-escalation	2					
Environmental awareness	3					
Your Intuition	1					

Proper positioning	2
Own the door	0
Situational awareness	2
Emotional awareness	2
Signs/symptoms of anger	3
Restraint education	1
Understanding the assault cycle	3
Escape planning	1

On the post violence incident follow up survey only one participant left a comment. The participant reported *“The patient was very agitated and did not speak English, therefore I was unable to know exactly what the patient was saying. My use of AVADE helped me recognize agitated body language and gave me the ability to use my blocking skills rather than put hands on the patient”*.

Discussion

The results of this quality improvement project show staff have increased confidence in coping with patient aggression after taking an educational intervention that focuses on de-escalation, awareness, defense, proper restraint use, legal components, and that case studies will increase healthcare workers confidence in coping with patient aggression. The pre and post Thackery’s coping with patient aggression survey was completed by 130 participants, across 20 different departments, and 13 job titles. Post implementation, using the post violence survey, participants report using the intervention, modified AVADE training, in violent events 86% of

the time. Using the 30 day follow up survey participants reported the education intervention was utilized in practice within one month of taking the course by 86% of survey participants, with 93% finding the training useful.

These findings are consistent with the literature review which found that educational, interventions increase staff confidence in managing patient agitation (Adams et al., 2017; Arbury et al., 2017; Arnetz et al., 2017; Asikainen et al., 2020; Baby et al; 2018; Badeaux et al., 2020; Christensen et al., 2022; Ferrara et al., 2017; Hamblin et al., 2017; Kynoch et al., 2011; Lamont & Brunero, 2018; Morphet et al., 2018; Somani et al. 2021; Thompson et al., 2022; Wilkins et al., 2019). The modified AVADE training is a combination of evidence-based interventions that improve healthcare worker safety and reduce violent incidents. During implementation, the participants reported that the program improved their confidence in coping with patient aggression, although statistical analysis still needs to be interpreted. The 30-day survey and post-violence survey have also identified that individuals reported using the training in their practice.

The theoretical framework for this project is the Plan-Do-Study-Act evidence-based practice model. This model is supported by evidence-based practice and is often used in quality improvement projects. This model was chosen as the theoretical framework because it is used to improve systems through planning, implementing, analyzing, and modifying (Gorenflo & Moran, 2010). This model was used to plan a review of the workplace violence prevention program, this modified program was then implemented, and data was collected related to the effectiveness of the program. The data were then analyzed and presented to key stakeholders. Following this quality improvement project the modified AVADE program does not need to be modified as the intervention was found to increase the confidence of staff managing patient aggression and gave staff tools to use in practice. It would be helpful to add refresher or follow

up courses as there appeared to be an increase in coping with patient aggression for individuals that had taken the nonmodified AVADE course prior. This shows evidence of improving healthcare workers confidence in coping with patient with repeat educational interventions. This informs future nursing practice because it identifies the importance of education on managing patient aggression. Further research could be conducted by tracking violent incidents pre and post the AVADE intervention.

Limitations

Limitations to this quality improvement project include the lack of racial demographic data. This is a limitation because it does not show that the data is consistent across different racial demographers. The data also cannot identify any racial disparities or intervention effectiveness across different groups. Racial demographic data is important to show that our study population is similar to the overall population with a mix of different races. Racial demographic is also important to look for racial congruence in violent incidents. Another limitation to this quality improvement project includes the number of participants in the 30 day follow up and post violence surveys. The 30 day follow up survey was only completed by 29 participants, and the post violence survey had even less with only 7 participants. Having a low number of participants influences the findings validity and generalizability. A small number of participants lowers that statistical power making it less likely to find a true correlation. Validity is also a limitation when having a small number of participants because each participants data has a larger impact causing less reliability estimates. There is also the potential impact of outliers in which they can be magnified skewing results. Due to this smaller sample sizes are harder to generalize to a group. This quality improvement project may include potential bias due to the self-reported measure of Thackrey's Confidence in Coping with Patient Aggression Instrument.

Self-reported measures can cause some response bias as individuals may respond in a way they feel is desirable. This project was conducted in a single hospital making external validity a limitation, as the results may not be able to be generalizable to other hospital settings. This quality improvement project also lacked a control group which makes it challenging to identify if the increased confidence came from the intervention directly. Also, the quality improvement project did not look at patient outcomes related to the intervention.

Facilitators and Barriers

The facilitators of this quality improvement project included only the primary researcher. Facilitators of the training program included eight trained AVADE instructors. These instructors teach each course in pairs of two. The primary researcher attended each class at the beginning and end to explain the quality improvement project and distribute the survey. The 30-day follow-up and the post-violence survey were distributed by the primary researcher. Barriers to the project included individuals only completing the pre-survey and then at the end of the class they did not complete the post-survey therefore removing themselves from the study. Another barrier was the limited participants in the post-violence survey. It was difficult to recruit participants for the 30-day follow-up and post-violence survey as they were distributed over email.

Conclusion

Violence, both physical and verbal, against healthcare workers is a problem that institutions need to address in order to increase job satisfaction, improve patient outcomes, and reduce harm to healthcare workers. Education in managing agitation among patients is lacking in healthcare program curriculum. This DNP project used an intervention of a modified AVADE program training to educate healthcare workers on awareness, vigilance, avoidance, defense, and escape from workplace violence and evaluated the effectiveness of the program. This quality

improvement project supports that training healthcare workers in managing patient aggression helps increase their confidence in coping with patient aggression and offers tools they can use in practice. This project is important to staff and the health care institution as it represents a means to increase healthcare worker confidence in coping with patient aggression. This quality improvement project could be replicated in other hospitals.

Implications for practice

This quality improvement project's implications for practice include improving healthcare workers confidence in coping with patient aggression, empowering nurses, and the need for educational follow up classes. This quality improvement project identified that an educational intervention improves healthcare workers confidence in coping with patient aggression. This increased confidence empowers nurses by giving them more confidence in managing patient agitation. It was also identified that participants who previously took a similar course also had an increase in confidence, supporting the need for follow up refresher classes.

Future Steps

There is a need for research related to the reduction of violent events related to the modified AVADE intervention. This quality improvement project supported that the modified AVADE training was helpful to increase health care worker confidence in coping with patient aggression however more data is needed to see if the intervention reduced violent events. A larger scale data collection across multiple hospitals that includes racial demographics is needed to identify how the modified AVADE course helps with violent events. In our quality improvement project, using the post violence survey, individuals involved in violent events reported that the modified AVADE course was helpful in violent events, but it was only limited to 7 participants. There is a need for a larger-scale study. In our facility, this training is only

mandatory for psychiatric and emergency department staff. Using the plan-do-study-act model it has been identified that there is need to advance the implementation of evidence-based care in other departments. The plan is to incorporate the training into orientation for new hires and highly encourage the training to staff in other inpatient departments. In future research, it would be beneficial to focus on the diversity of the study participants including race and ethnicity.

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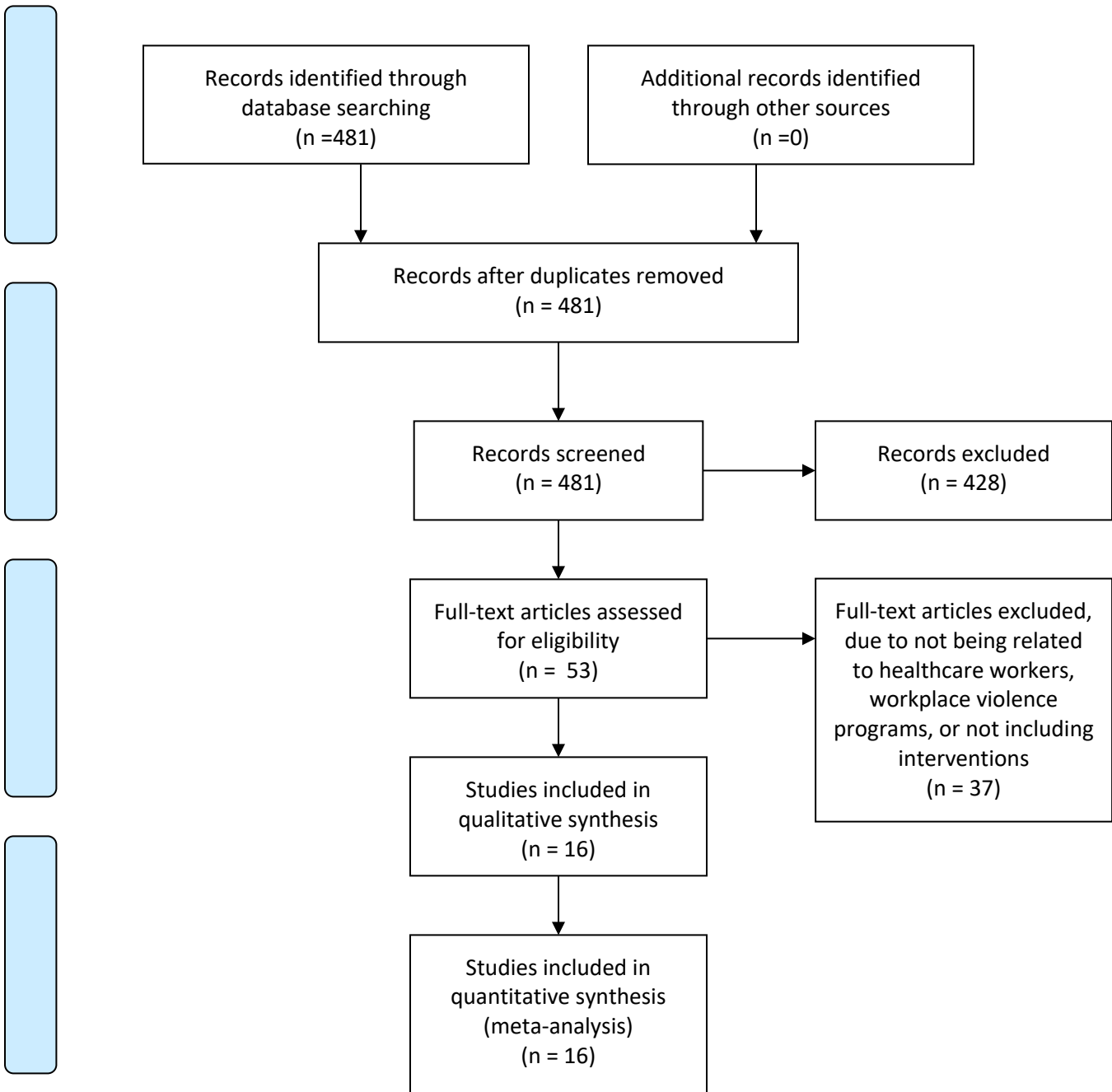
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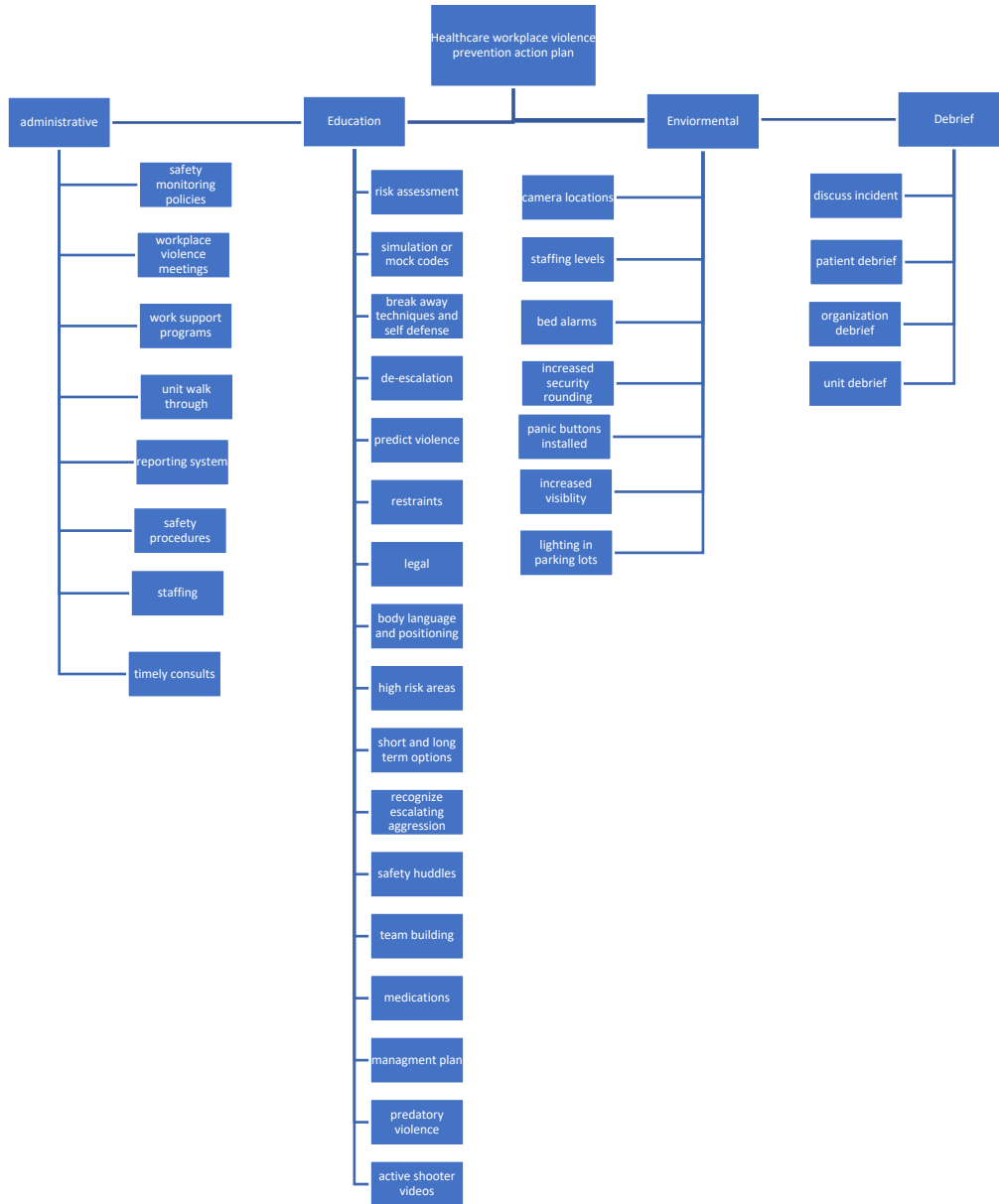
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Appendix A: PRISMA Flowchart

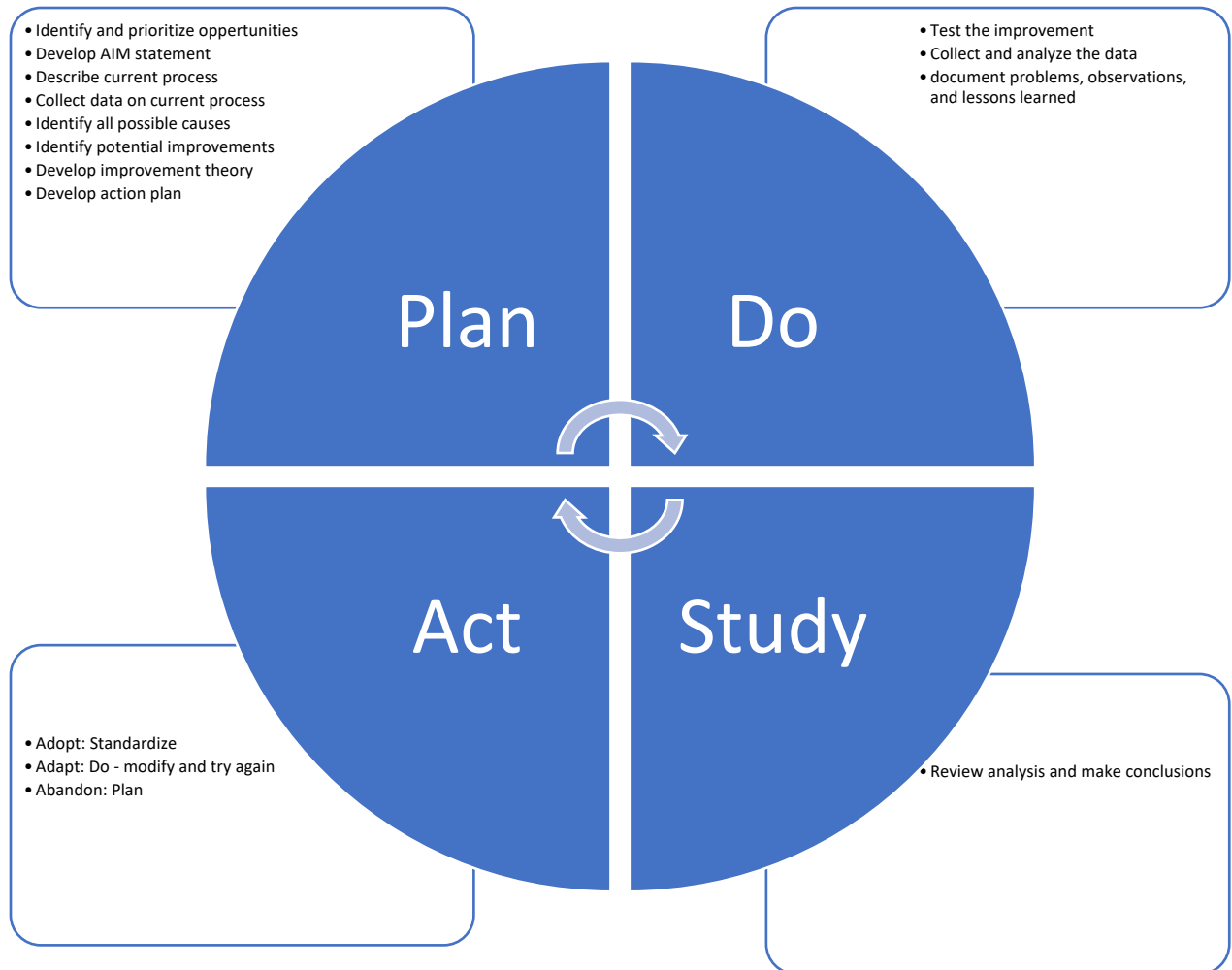


Appendix B: Workplace Violence Prevention Model



Appendix C: Plan-Do-Study-Act Model

Adapted from Gorenflo and Moran (2010)



Appendix D: 30 Day follow-up email

Dear (healthcare worker),

You have recently taken the modified AVADE course. We would like to ask you a few questions related to the use of the skills used in the course. It is four questions, your involvement in this research will help us to better understand workplace violence and work to reduce these incidences.

The survey can be found here: [LINK](#).

Thank you for your participation,

-Jessica Cappucci

Appendix E: 30-day follow-up questionnaire

Thirty days ago, you took the Modified AVADE training program.

1. Have you used any aspect of the training while completing your job?
 - a. Yes
 - b. No
2. Was the training helpful?
 - a. Yes
 - b. No
3. If you answered yes to the previous questions what techniques were used? (Select all that apply)
 - a. De-escalation
 - b. Body language
 - c. Signs and symptoms of anger
 - d. Environmental awareness
 - e. Self-awareness
 - f. Situational awareness
 - g. Emotional awareness
 - h. Your intuition
 - i. Understanding the assault cycle
 - j. Understanding violence and who commits violence.
 - k. Defensive blocks
 - l. Defensive strikes
 - m. Escape planning.
 - n. Proper positioning
 - o. Own the door.
 - p. Restraint education
4. Any additional information please do not include patient identifying information (open-ended)

Appendix F: Safety event email follow-up

Dear (healthcare worker),

We have identified that you have been involved in a safety event which included a violent or agitated patient. We would like to ask you a few questions related to this event for workplace violence research. It is four questions, your involvement in this research will help us to better understand workplace violence and work to reduce these incidences.

The survey can be found here: [LINK](#).

Thank you for your participation,

-Jessica Cappucci

Appendix G: Safety event follow-up questionnaire

We have identified that you have recently been involved in a safety event with a violent or agitated patient.

1. Did you use any aspect of the Modified AVADE training while being involved in the violent or agitated patient involved in this safety event?
 - a. Yes
 - b. No
2. Was the training helpful?
 - a. Yes
 - b. No
3. If you answered yes to the previous questions what techniques were used? (Select all that apply)
 - a. De-escalation
 - b. Body language
 - c. Signs and symptoms of anger
 - d. Environmental awareness
 - e. Self-awareness
 - f. Situational awareness
 - g. Emotional awareness
 - h. Your intuition
 - i. Understanding the assault cycle
 - j. Understanding violence and who commits violence.
 - k. Defensive blocks
 - l. Defensive strikes
 - m. Escape planning.
 - n. Proper positioning
 - o. Own the door.
 - p. Restraint education
4. Any additional information please do not include patient identifying information (open-ended)

Appendix H: Hospital letter of approval

Removed for confidentiality.

Appendix I: Thackery Confidence in Coping with Patient Aggression Instrument

(Thackrey, 1987)

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

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

1	2	3	4	5	6	7	8	9	10	11
---	---	---	---	---	---	---	---	---	----	----

Low confidence

High confidence

Appendix J: IRB Approval

4/23/23, 11:49 AM

Protocols

PROTOCOLS



**#4405 - Workplace Violence Prevention in Healthcare:
Evaluating the Impact of a Modified AVADE Training Program**

Protocol Information

Submission Type	Review Type	Status	Time in Current Status
New	--	Submitted for Review	Since April 23 – a few seconds

General Information

Please Note: Personnel listed with Full Access can edit the Protocol, but only the listed Principal Investigator has access to perform the initial Submit action of the Protocol.

Principal Investigator

Cappucci, Jessica

Department

Coll: Nursing

Protocol Title

Workplace Violence Prevention in Healthcare: Evaluating the Impact of a Modified AVADE Training Program

Study Personnel

Appendix L: Budget

Paper \$50