Evidence-Based Verbal De-escalation Techniques for the Family Nurse Practitioner: Education and Simulation

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Evidence-Based Verbal De-escalation Techniques for the Family Nurse Practitioner:

Education and Simulation

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Abstract

Background: Healthcare workers are 4 times more likely to be exposed to workplace violence than workers employed in private industry, with assault rates as high as 7.8 per 10,000 workers. The National Institute for Occupational Safety and Health defines workplace violence as “violent acts, including physical assaults, and or threats of assault, directed toward persons at work or on duty” (OSHA, 2015, p. 2). Verbal de-escalation techniques that assist with care of the agitated patient are not routinely taught to Family Nurse Practitioners (FNPs) throughout their years of advanced coursework, yet it is something they are likely to encounter given the research highlighting the disturbing assault rates against healthcare providers. Methods: In an effort to improve the delivery of patient centered care and enhance the safety of FNPs in the outpatient setting, a verbal de-escalation educational module and live in-person simulation training was created to serve as a resource to guide the behavioral management of an agitated patient. The aim of this evidence-based project was to provide practicing FNP clinicians and FNP students with training in verbal de-escalation techniques designed to promote workplace safety, reduce rates of violence against providers, and ultimately enhance provider comfort and satisfaction when working with an agitated patient. Results: A total of 14 participants, 10 FNP students and 4 FNP clinicians, participated in the educational intervention outlined by this project. Data analysis demonstrated a dramatic increase (117%) in the participant’s confidence in their ability to implement verbal de-escalation techniques following the educational intervention.

Conclusions: Overall, this project was a cost effective way to supplement knowledge and experience with evidence-based interventions aimed to assist the FNP with successful verbal de-escalation of an agitated patient.

Keywords: de-escalation, verbal, nurse practitioner, aggression management, workplace violence
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SECTION II: Introduction

Background Knowledge

The National Institute for Occupational Safety and Health (OSHA) defines workplace violence as “violent acts, including physical assaults, and or threats of assault, directed toward persons at work or on duty” (OSHA, 2015, p. 2). Healthcare workers are 4 times more likely to be exposed to workplace violence than those employed in private industry, with assault rates as high as 7.8 per 10,000 workers. This compares to the national average of only 2.1 assaults per 10,000 workers found in non-healthcare settings (OSHA, 2015). These numbers are significant given the known underreporting of such incidences that are notorious amongst healthcare workers. It is estimated that as many as 80% of all abusive acts committed by patients are not reported by healthcare staff (Erickson & Williams-Evans, 2000). Reasons for underreporting include: belief that being assaulted by patients “goes with the job,” lack of understanding as to what constitutes an assault, fear of reprimand for something that the healthcare worker did or did not do to provoke the attack, and the time needed to report an incident.

The workplace violence position statement by the American Association of Critical-Care Nurses (AACN) which includes statistics provided by the Bureau of Labor Statistics states that healthcare workers have one of the highest rates of nonfatal assault injuries in the workplace. Bedside nurses are three times more likely to experience violence than other professionals with 82% of surveyed nurses reporting at least one career assault (Erickson & Williams-Evans, 2000).

Physicians are not far behind with 51% of MDs reporting at least one assault in the previous 6 months by a patient (Gates, Ross, & McQueen, 2006), and 28% of Emergency Room Physicians reporting a physical assault within the previous 12 months (Kowalenko, Walter, Khare, & Compton, 2005). A 2010 Canadian study reported findings which indicated that 29%
of primary care physicians had been victims of patient-driven aggressive behavior in the one month preceding the survey (Miedema et al., 2010). Of those affected physicians, nearly all reported experiences with verbal insults and verbal abuse. Twenty-six percent of affected physicians experienced moderate aggression, such as damage to personal property, and 8% reported being victims of serious physical violence and/or sexual assault (Miedema et al., 2010).

A recent poll taken on the anonymous physician website Sermo, which boasts nearly 600,000 members worldwide, conveyed similar findings with 71% of physicians reporting having been both verbally and/or physically assaulted by a patient at some point throughout their careers (Sermo, 2015).

**Local Problem**

Workplace violence in the healthcare setting is a complex issue with a wide array of moving parts. Agitated and aggressive patients can be found throughout a variety of healthcare settings from inpatient to outpatient, rural to urban, and pediatric to geriatric. This makes it extremely difficult to isolate precipitating factors when searching for solutions that aid in workplace violence reduction.

With the recent push to shorten hospital length of stay and focus attention on home health and outpatient primary care (Kutscher & Evans, 2013), there is precedent to expect an increase in the prevalence of aggression towards primary care physicians and primary care nurse practitioners. With 71% of physicians reporting having never received any type of formal workplace violence training (Phillips, 2016), how can we expect providers to effectively manage aggressive and agitated patients without the traditional inpatient resources of behavioral response teams? When violent outbursts occur in the inpatient setting and patients are deemed to be uncontrollable, it is not unusual for the provider to request assistance from security officers,
administer emergency medications, apply physical restraints, and seclude the patient. But what happens when you are the lone provider in a small rural clinic with limited staffing resources? This begs the question, what can be done to assist outpatient primary care providers with de-escalation of the agitated patient before violent outcomes are met?

**Intended Improvement**

The aim of this project was to improve the delivery of patient centered care and enhance the safety of Family Nurse Practitioners (FNP) through the implementation of targeted education and simulation training for the prevention and management of agitated patient behaviors in the outpatient clinical setting. In an effort to fill the gap identified by the Occupational Safety and Health Administration (OSHA, 2015) which has recognized a lack of training for staff in de-escalation of hostile and assaultive behaviors, this project was designed to address the needs of the practicing outpatient FNP clinician and the anticipated needs of FNP students.

By developing, implementing, and evaluating this program, the expectation was to stimulate an organized response to patients presenting with acutely disruptive or aggressive behaviors in order to optimize care and maintain safety of the FNP and ancillary staff members in the outpatient setting. The targeted education and simulation training provided by this project will serve to promote workplace safety by providing easy tips for the quick verbal de-escalation of agitated behaviors, reduce the rate of violence against providers, and ultimately improve provider satisfaction when working with the behaviorally challenging patient.

**Review of the Evidence**

A comprehensive electronic review of the literature was performed utilizing the databases Medline, CINAHL, PubMed, and the Cochrane Library for English language articles published between the years 2000 and 2016 with no limits applied to study type. Keywords searched
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included *de-escalation, verbal, physician, nurse practitioner, aggression management,* and *workplace violence.* Results yielded 31 articles, of which 8 were chosen for review based on relevance to the research questions. The chosen articles included an assortment of expert consensus guidelines, thematic meta-synthesis, cross-sectional investigative studies, qualitative investigative studies, and convenience survey sampling. Considering the variety of academic evidence regarding this topic, a decision was made to utilize a tool that would better assess validity and aid in critique of the literature. The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) *Research Evidence Appraisal Tool* was chosen to assess the validity of literary evidence by critiquing the study design, study results, study conclusions, strength of evidence (level I, level II, level III, level IV, and level V), and assign a quality rating of either A, B, or C (The Institute for Johns Hopkins Nursing, 2012). A comprehensive review of the evidence utilizing the JHNEBP tool can be found in Appendix C.

**Prevalence of aggression and violence against medical providers.** Workplace violence in the healthcare setting is an underreported, pervasive, and persistent problem that has been consistently tolerated and essentially ignored (Philips, 2016). In an effort to validate such unforgiving claims, a 2013 descriptive exploratory research study by Abualrub and Khawaldeh (2013) set out with a primary focus to examine the incidence, frequency, and contributing factors to workplace violence amongst physicians and nurses in rural Jordan. A total of 396 nurses and 125 physicians submitted completed questionnaires that were collaboratively developed by the International Labor Office, the International Council of Nurses, the World Health Organization, and Public Services International. Study findings indicated incidence of physical violence in rural Jordan to be lower than those reported by other international studies; with 18.4% of physicians and 13.1% of nurses reporting exposure to physical violence (Abualrub &
Comparison studies in Australia indicated slightly higher incidence rates of 28.6% amongst nurses (Opie et al., 2010) and 20% of physicians (Tollhurst et al., 2003) experiencing direct exposure to physical violence.

To further expand on this complex issue of workplace violence and highlight the often ignored occurrence of verbal abuse against medical providers, a 2015 study created a postal questionnaire to be sent out to a random sample of 1500 primary care physicians in Germany (Vorderwulbecke, Feistle, Mehring, Schneider, & Linde, 2015). With the authors hypothesizing that aggressive behaviors towards providers is an evidently common occurrence, they set out with three objectives: (1) to gauge a sense of personal safety amongst primary care providers, (2) determine the proportion of primary care providers who have ever experienced aggressive behaviors within their practice, and (3) to document the most serious aggressive incidents for participants (Vorderwulbecke et al., 2015). Of the 831 survey respondents, 91% of primary care physicians reported having been confronted with aggressive behaviors (in some form) throughout the course of their careers, and 73% reporting that experience having occurred within the preceding 12 months (Vorderwulbecke et al., 2015). Study findings also indicated that female physicians (60%) were more likely to be subjected to aggressive behaviors than their male (51%) counterparts (Vorderwulbecke et al., 2015).

Based on the summarized data, the study authors estimated that one in ten primary care physicians had been confronted with aggression or violence within the preceding 12 months and that “almost every surveyed physician had experienced aggression at some point in their career” (Vorderwulbecke et al., 2015, p. 163) concluding that it is highly advisable to introduce the topic of workplace violence into medical education and to devise strategies for safely managing aggression in the healthcare setting. Workplace violence is a significant issue that requires
immediate attention in order to minimize the distressing impact it continues to have on our healthcare systems.

**Verbal de-escalation techniques for the agitated patient.** While some articles touched on the efficacy and need for verbal de-escalation, few relevant articles were found to have descriptions regarding specific verbal de-escalation techniques. Noting this gap in the literature along with the pure lack of randomized controlled trials and rigorous systematic reviews, Price & Baker (2012) compiled a thematic synthesis of qualitative studies designed to shed light on verbal de-escalation best practices. From this data synthesis, seven themes to successful verbal de-escalation emerged: (1) characteristics of effective de-escalators, (2) maintaining personal control, (3) verbal and non-verbal skills, (4) engaging with the patient, (5) when to intervene, (6) ensuring safe conditions for de-escalation, and (7) strategies for de-escalation (Price & Baker, 2012). In addition to these seven core themes, Price & Baker (2012) also highlighted the importance of facilitating expression and shared problem solving, offering alternatives to aggression, and setting limits all while being mindful of authoritarian interventions.

Similar conclusions were reached by the American Academy of Emergency Psychiatry (AAEP) who as a result were prompted to develop a consensus statement to supplement the limited availability of verbal de-escalation literature. The AAEP Project BETA De-escalation Workgroup Consensus Statement has outlined ten domains of verbal de-escalation designed to assist the non-psychiatric provider with care of the agitated patient: (1) respect personal space, (2) do not be provocative, (3) establish verbal contact, (4) be concise, (5) identify wants and feelings, (6) listen closely to what the patient is saying, (7) agree or agree to disagree, (8) lay down the law and set clear limits, (9) offer choices and optimism, and (10) debrief the patient and staff (Richmond et al., 2012). The purpose of these 10 domains aims to achieve 4 main
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objectives: (1) ensure the safety of the patient, staff, and visitors, (2) help the patient manage their emotions and distress to better maintain control of their behavior, (3) avoid the use of restraints when at all possible, and (4) avoid coercive interventions that escalate agitation (Richmond et al., 2012).

Patients expressing threatening and dangerous behaviors place providers in an uncomfortable situation that may potentially put them at risk for unwanted injury and increase mental and emotional stressors. The AAEP (Richmond et al., 2012) advocates for a more contemporary and non-coercive approach with a goal to verbally engage the patient, establish a collaborative relationship, and continue by verbally de-escalating the patient out of their agitated state.

**Tools for the evaluation of verbal de-escalation techniques.** Based on literary evidence, it is apparent that workplace violence in the healthcare setting is a complex issue that requires immediate attention. Although the question now is not if de-escalation training should be provided, but whether or not the chosen training modality improves outcomes in an effective and meaningful manner (Zarola & Leather, 2006).

In an attempt to examine the efficacy of de-escalation training, Nau, Halfens, Needham, and Dassen (2009) pursued qualitative investigations that identified seven topics consistent with effective de-escalation behaviors: (1) value the client, (2) reduce fear, (3) enquire about the client’s questions and anxiety, (4) provide guidance to the client, (5) work out possible agreements, (6) remain calm, and (7) the absence of risky behavior. These seven topics were used as a framework to develop a new German language tool, the *De-escalating Aggressive Behavior Scale* (DABS), aimed to measure the efficacy of de-escalation training. In an effort to develop and test the psychometric properties of DABS, an initial study by Nau et al. (2009) was
conducted in three phases. Phase one focused on scale item generation, phase two on scale item selection, while phase three set out to investigate scale item reliability. Video recordings of nursing students engaging in de-escalation scenarios were provided to 15 German speaking de-escalation trainers for evaluation using DABS. Data analysis found good internal consistency when evaluating the scale’s validity. Suggested study findings concluded that DABS is a reliable method which can be used to evaluate training programs designed to target de-escalation and aggressive behavior management.

Having evaluated the internal validity of DABS, Nau, Halfens, and Dassen (2010) proceeded with a follow-up study aimed to examine the impact of de-escalation training for students at a large school of nursing in Germany. A cross-sectional longitudinal study consisting of a pre-posttest utilized a within-and-between groups design to best evaluate the intended 24 training sessions. Themes of the interventional de-escalation training included (1) prevention, (2) assessment of occurrence, (3) dealing with the patient, and (4) coping and aftercare (Nau et al., 2010). As part of this study, two groups of nursing students encountered two different scenarios with simulated patients after completing the required de-escalation training. One hundred fifty six of these encounters were recorded by de-escalation experts and reviewed using DABS. Results indicated that performance levels of the students who had been trained increased significantly from 2.74 to 3.65 (Nau et al., 2010). Interestingly enough, incidental findings suggested that nursing students’ performance does not naturally improve as more patient experience is gained. The study authors concluded that it is reckless to assume that healthcare providers will learn aggression management “on the job” and instead, de-escalation training is needed in order to improve the nursing students’ comfort and performance in de-escalating aggressive behaviors (Nau et al., 2010).
Building on the evidence presented by Nau et al. (2009; 2010), Mavandadi, Bieling, and Madsen (2016) aimed to enhance the original DABS scale and validate an English modified version (EMDABS). The seven topics consistent with effective de-escalation behaviors found in DABS were retained for EMDABS, with the additional improvement of clarifying definitions for each topic. These clarifying definitions consist of one sentence descriptions of what constituted best, acceptable, and least desirable practice for each of the seven topics (Mavandadi et al., 2016). To evaluate the newly modified EMDABS, the authors reviewed 272 video simulations taken from a large Canadian mental health hospital. Findings that demonstrated good inter-rater agreements lead the authors to conclude that there is potential for EMDABS to be widely disseminated for use in evaluating the effectiveness of various de-escalation training programs. This is a much needed advancement in de-escalation evaluation considering that the current state infers efficacy of de-escalation training based primarily on injury reports and use of coercive measures.

Unfortunately, verbal de-escalation techniques for the acutely agitated or aggressive patient are skills that are not routinely taught to Family Nurse Practitioners during their years of advanced coursework. Yet, assault is something that they will likely encounter given the data present in the literature regarding verbal and physical assault rates on healthcare providers. Being mindful of the evidence based de-escalation domains and themes, engaging the patient and helping them to become an active partner in the de-escalation process will help to decrease distress amongst providers, decrease provider turnover rates, and ultimately improve provider and patient satisfaction.
Theoretical Framework

This project was guided by Abraham Maslow’s theory of human motivation. Maslow’s discussion of his 1943 theory of human motivation unearthed an interesting notion in regards to how humans perceive safety. “Practically everything looks less important than safety. A man, in this state, if it is extreme enough and chronic enough, may be characterized as living almost for safety alone” (Maslow, 1943, p. 7).

The need to safely practice medicine is often overshadowed by the stressful and chaotic environments in which many providers find themselves working. Being mindful of the belief that violence comes with the job (Erickson & Williams-Evans, 2000), it is no surprise that providers may subconsciously attempt to minimize the effects of repeated physical, verbal, and emotional abuse. Maslow highlights the traumatizing effects such events may have on a person by highlighting observations of children whose reactions are more obvious. Stating that quarreling, physical assault, outbursts of rage, speaking harshly, or actual physical punishment often “elicits such total panic and terror in a child that we must assume more is involved than physical pain alone” and “obviously obscures the higher motivations” (Maslow, 1943, p. 7).

Being mindful of the stifling effect of threatened safety, this theoretical framework served to provide an organized response to patients presenting with disruptive or aggressive behaviors. The doctoral trained FNP is unique in the healthcare field in that they are academically trained to pursue ways to advance the nursing profession by providing evidence based, quality patient care. In order to achieve this, FNPs need to be able to have their basic needs met before they can effectively move up through the pyramidal hierarchy of needs (see Appendix E) to reach professional self-actualization as a family nurse practitioner.
SECTION III: Methods

Ethical Issues

The ethical principles of autonomy, beneficence, nonmaleficence, fidelity, and justice are seen by many as the cornerstones of nursing practice (Silva & Ludwick, 2006). This project strives to endorse nursing ethical principles through targeted promotion of justice, beneficence, and nonmaleficence. The ethical principle of justice refers to the equal and fair distribution of resources; implying that everyone has a right to the equal distribution of goods and services regardless of their contributions (Butts & Rich, 2008). Beneficence comes from a desire to do good and take positive action to help others while nonmaleficence advocates for the avoidance of harm; a core principle in all avenues of healthcare (Beauchamp & Childress, 2009).

If an agitated patient can be successfully de-escalated before negative outcomes are met, the FNP can be more apt to collaborate with the patient to develop a fair and sustainable plan of care that is specifically tailored to the needs of the patient. Considering that healthcare providers tend to endorse negative stereotypes against patients with mental illness (Stull, McGrew, Salyers, & Ashburn-Nardo, 2013), it is not unreasonable to postulate that providers may also hold implicit biases against patients with whom they have had aggressive or violent interactions. By providing verbal de-escalation training to FNPs, this project aimed to diminish these implicit biases and promote safe, quality care for all patients who providers may subconsciously marginalize for aggressive outbursts. Thus, allowing the FNP to better advocate for a professional practice rich in justice, beneficence, and nonmaleficence.

This project was deemed to be an evidence-based practice quality improvement project by the University of San Francisco School of Nursing and Health Professions Doctor of Nursing Practice faculty. With the intention to enhance provider knowledge of verbal de-escalation
techniques, this project was deemed exempt from Institutional Review Board (IRB) for the Protection of Human Subjects approval for implementation. All rules and regulations outlined by the Health Insurance Portability and Accountability Act (HIPAA) were upheld and no identifying patient information was used.

Planning the Intervention

This author held the primary responsibility of project coordination aimed to facilitate the application of varying components of the three distinct phases of implementation. A work breakdown structure was created to assist with planning and implementation of the proposed project (see Appendix G).

The author of this Doctor of Nursing Practice (DNP) project worked closely with DNP academic committee advisors who hold expertise in psychiatric/mental health nursing and clinical based simulation training to identify current gaps in nursing practice (see Appendix F for gap analysis) related to verbal de-escalation education and training. In an effort to fill these identified gaps in practice, an initial proposal to USF DNP faculty was made to present educational training material only to USF FNP students. However, upon further discussion with committee advisors, it was decided that practicing FNP clinicians would also serve to benefit from additional training and the project was split into three phases of implementation to target the specific needs of each group.

Phase one. The University of San Francisco is a private Jesuit Catholic University located in San Francisco, California. Current enrollment at USF is approximately 10,172 students, with 1,300 of those students enrolled in the School of Nursing and Health Professionals. Current curriculum dictates that USF FNP students enrolled in N735/N736, Advanced Assessment and Differential Diagnosis, receive education regarding various mental
health disorders commonly seen in the outpatient setting and the appropriate utilization of screening tools to assist with diagnosis and treatment. While there is a great deal of emphasis placed on assessing, diagnosing, and treating mental health disorders, there is a gap in education regarding the management of patients who present with acute agitation or aggression in the outpatient setting that may be exacerbated by underlying mental health disorders.

Through a collaborative approach with committee members, the proposal for an educational training package which included an online PowerPoint presentation and live simulation training targeted towards identification and management of agitated behaviors and the utilization of verbal de-escalation techniques in the outpatient clinical setting was approved for implementation at USF.

**Phase two.** This phase of the project was aimed towards implementation of verbal de-escalation training at the Native American Health Center (NAHC) in Oakland, California with focus on the educational needs of the clinic’s practicing clinicians and FNP students. NAHC is a non-profit healthcare organization that has served the California Bay Area’s Native American and under-served populations since 1972. NAHC provides comprehensive care services which includes family health, behavioral health, pregnancy, women’s health, and dental services. NAHC’s Oakland clinic employs both physicians and nurse practitioners who successfully manage the care of approximately 5,021 patients with an average of 21,284 visits per year (OSHPD, 2010). The majority of NAHC’s patient population come from low-income and underserved populations of Alameda county, with many of the patients presenting with complex psychosocial needs that can oftentimes be a barrier to their care. Given NAHC’s historical patient population, a decision was made through close collaboration between this author and the
lead FNP educator at NAHC, to present the topic of verbal de-escalation to the practicing clinicians and FNP students at the clinic.

Prior to conducting the in-person educational training, a pre-post survey was created (see Appendix N) to better assess the practicing clinician and FNP students’ current comfort with care of the agitated patient. The survey consisted of 5-point Likert-type scale questions in which respondents were instructed to identify the number that best corresponds to their position on the question, ranging from strongly disagree to strongly agree. Also included on the survey was a blank space for free text comments. Questions on the survey included: 1) I frequently interact with agitated patients, 2) I am confident in my ability to verbally de-escalate an agitated patient in a safe and effective manner, 3) I am confident in my ability to maintain my personal safety while in the presence of an agitated patient 4) I have received adequate education on how to safely and effectively verbally de-escalate an agitated patient, and 5) I am confident in my ability to implement verbal de-escalation techniques when working with an agitated patient.

The educational training package was tailored to address the needs of the clinic and included the pre-post survey questionnaire, a PowerPoint presentation entitled “Risky Business: Verbal De-escalation of the Agitated Patient for the Family Nurse Practitioner” (see Appendix M), and presentation of a previously recorded USF student simulation video as a means to stimulate discussion around the application of verbal de-escalation themes.

**Phase three.** In the fall of 2016, the University of San Francisco School of Nursing and Health Professionals began organizing monthly “Lunch and Learn” events on Friday afternoons. These events provide an opportunity for USF Doctor of Nursing Practice students and community collaborators to present practice relevant evidence-based topics to fellow DNP/FNP students and USF FNP faculty members. In an effort reach an even broader audience that
included both students and practicing FNPs, the verbal de-escalation educational training package was selected for presentation at the March 24th Lunch and Learn event. The training package included the same pre-post survey questionnaire, the same PowerPoint presentation entitled “Risky Business: Verbal De-escalation of the Agitated Patient for the Family Nurse Practitioner,” and presentation of the previously recorded USF student simulation video.

**Timeline.** In June 2016, this author identified a gap in FNP education when faced with an acutely agitated patient in the outpatient clinical setting. Driven by discomfort and unfamiliarity surrounding the care of an acutely agitated patient, a review of the literature illuminated the current gap in provider education when it comes to safely and effectively managing an agitated or aggressive patient. Recognizing the opportunity for improving the safety of FNPs in the outpatient setting, a proposal for the implementation of an evidence-based quality improvement intervention was submitted to USF DNP faculty for approval in July 2016. In an effort to organize and streamline project development and implementation, a Gantt chart (see Appendix H) was created to provide this author and DNP academic committee advisors with a graphic representation of the interventional process.

By focusing on identifying current gaps in practice and identifying the severity of the issue of workplace violence against healthcare providers, the initial development phase aimed to bridge these gaps with targeted evidence-based educational interventions. Creation and development of the online educational material and simulation scenario occurred in September 2016 in conjunction with the identification of an experienced actor for the live-action simulation experience. The implementation of phase one began in October 2016 with the presentation of a live-action simulation scenario to the USF FNP Cohort #6 students. The simulation was designed to observe their interactions with the actor and assess their baseline knowledge of
managing acutely agitated patients in the outpatient clinical setting. Following the live-action simulation, the FNP students were granted access to the online educational material which the author used to help facilitate a candid debriefing of the simulation experience and its relevance to future real-life clinical experiences.

Phase two implementation began in January 2017 following a presentation of the educational training material to NAHC’s compliance officer and lead FNP educator. A collaborative decision was made to present the topic of verbal de-escalation to both the practicing clinicians and FNP students at the clinic. In-person trainings were conducted throughout the months of February and March. A pre-post intervention survey was administered prior to and immediately following presentation of the educational information. Results of the survey were collected and saved for analysis at a later time.

Phase three implementation occurred on March 24, 2017 at a pre-organized “Lunch and Learn” event at USF. These events are organized by the School of Nursing and Health Professions and allow for DNP students to present various evidence-based topics to fellow DNP/FNP students as well as FNP faculty members. Again, the same pre-post intervention survey was distributed to all attendees prior to and immediately following presentation of the educational information. Results of the survey were again collected and saved for analysis at a later time.

**SWOT Analysis.** In order to identify the strengths of this project and mitigate any potential barriers prior to moving forward with the proposed interventions, an examination of the project’s various strengths, weaknesses, opportunities, and threats (SWOT) was conducted (Appendix I).
**Strengths.** What makes this project unique is that it strives to highlight the often swept aside issue of workplace violence against healthcare providers. By providing verbal de-escalation training to practicing FNPs and student FNPs, this DNP driven project strives to promote provider safety and improve patient care outcomes through evidence-based interventions. By providing education to help identify and facilitate timely verbal de-escalation, the newly trained FNP will have the tools necessary to refocus the agitated patient and encourage them to become active participants in their plan of care, all while promoting provider and patient safety.

**Weaknesses.** While it is exciting to identify the strengths of this project, it is also important to recognize potential weaknesses that may impact the overall success of this project. Given the intrinsic nature of the project, this author anticipated that it would be challenging to collect substantial data to support an immediate benefit to this project. Historically, the success of de-escalation training has been measured against injury reports and the use of coercive measures like physical restraints or seclusion. This type of data is readily available and easily analyzed in large acute care inpatient healthcare settings. However, it becomes exceedingly difficult to measure the success of de-escalation training in smaller outpatient clinical settings where physical violence or the application of coercive management measures may be less prevalent.

**Opportunities.** Like most evidence-based practice changes, the successful implementation of this project faced its fair share of challenges. Overcoming those difficulties undoubtedly proved to be a worthwhile endeavor given the potential opportunities offered by this project. Based on the findings of the gap analysis, many FNPs do not feel sufficiently prepared to address the oftentimes complex psychosocial needs of their patients. This poses a potential
problem considering that psychosocial needs are likely to escalate if left unaddressed. This escalation has the likelihood to result in an aggressive behavioral outburst that threatens to undermine the provider’s safety as well as their relationship with the patient. This project helped to mitigate this gap in the educational management of agitation and enhance rapport and communication between the patient and the provider. By empowering FNPs to identify and manage escalating behaviors in a timely manner, they can better advocate for patient and provider safety through real time de-escalation role-modeling to ancillary clinic staff. Ultimately, the goal of this project was to raise awareness of the importance of incorporating verbal de-escalation training into standard FNP curriculum.

**Threats.** Being able to identify threats and barriers to a project ultimately contributed to the overall success of this project and its long-term sustainability. Focusing on identifying various threats was critical to elicit discussions on how to effectively address them. Inadequate stakeholder buy-in was an obvious concern that was immediately identified. Informal conversations with student FNPs revealed that the majority were eager to participate in verbal de-escalation training. However, while similar enthusiasm was displayed at NAHC, it is important to be mindful of the environment in which the practicing FNPs find themselves.

NAHC is a busy outpatient clinic that sees a large volume of patients on a daily basis with most FNPs at the clinic seeing an average of 18-22 patients per day. Oftentimes, the FNP employed at this clinic may find themselves feeling extremely pressed for time, which may result in them being less likely to dedicate the time needed to verbal de-escalation training.

**Cost-benefit analysis.** Outlining the financial budget and potential cost avoidance of this project is a critical factor in ensuring its long term viability. The anticipated cost for development and implementation of this project was relatively minimal at $1,510. Given this
author’s commitment to the success of this project, the actual cost of implementation resulted in $100 of out-of-pocket expenses paid to the Simulation Actor. The value of this project is highlighted by its potential cost avoidance when considering the high cost associated with employee injuries resulting from physical violence and the recruitment of new Family Nurse Practitioners.

The Occupation Safety and Health Administration (OSHA, 2015) reports on average that healthcare workers who require treatment for violent injuries can cost an organization approximately $3,200 per injury. However, it is important to note that this number is likely higher given the salaries of healthcare providers in the Bay Area when compared to national averages. Total costs associated with the hiring and onboarding of a new Family Nurse Practitioner, in order to replace one who has left an organization due to emotional burnout or physical injury, can be upwards of 213% of their annual salary (Merhar, 2016). With the average salary of Bay Area Nurse Practitioners hovering around $150,000 there is a potential estimated cost avoidance of $317,990-319,400 per provider. Given the low cost of development and implementation of this project, it is easy to see the value a project of this nature holds for employers (see Appendix J for further breakdown of the cost analysis).

**Communication.** In order to meet the objectives identified by the project’s timeline, effective communication amongst primary project stakeholders is key to overall success. A communication matrix (Appendix K) was constructed to serve as a correspondence guide between this author, committee advisory members, and targeted project stakeholders. At the core of the project’s communication matrix is this author who served as a communications facilitator amongst the project’s stakeholders; including the USF FNP students, USF faculty, simulation actor, DNP academic advisory committee, and the organizational setting (NAHC).
Effective communication between this author and the project stakeholders was managed through frequent in-person contact and use of e-technologies such as email and Canvas which provided access to the USF FNP students for the online educational material. These methods have been essential in easily notifying stakeholders of the project’s current status, progress, and newly identified barriers.

**Planning the Study of the Intervention**

Given the inherent nature of this project, the author anticipated that it would be challenging to collect substantial real-time data to demonstrate an immediate benefit to this project. Historically, the success of de-escalation training has been measured against injury reports and the use of coercive measures like physical restraints or seclusion. This type of data is often readily available and easily analyzed in large inpatient healthcare settings. However, it becomes exceedingly difficult to measure the success of verbal de-escalation training in smaller outpatient clinical settings where verbal abuse is more common than the infrequently seen physical violence or application of coercive measures. In a rigorous study environment, an evaluation tool such as EMDABS would be beneficial in retrospectively assessing the impact of verbal de-escalation training. However, utilization of the EMDABS tool is difficult considering the oftentimes isolated and chaotic real-time nature of these interactions in the outpatient clinical setting.

While planning the study intervention, a brief retrospective chart review was conducted at NAHC using their electronic health record (EHR) system, NextGen. This chart review was conducted on NAHC patients (n=10) with a known history of complex psychosocial needs that often result in aggressive outbursts during clinic visits. As a result of the chart review, the author was unable to identify unique measureable outcomes that could be easily tracked and analyzed.
through the NextGen charting system. Findings indicated that providers (FNPs and MDs) were likely to write progress notes that described the agitated outburst, recognize potential contributing factors, and identify a plan of care based on outcomes of the event. However, none of the progress notes were found to follow a standardized template and failed to contain discussions of utilization of de-escalation tactics which would make it difficult to evaluate the short-term efficacy of verbal de-escalation training.

Recognizing this as a potential project barrier, discussions between this author and the DNP committee chair determined that an effective means of evaluating the short-term impact of verbal de-escalation training would be to amalgamate and compare results of the pre and post intervention survey questionnaire and identify common discussion themes. It was anticipated that results of the post-intervention survey analysis would demonstrate: 1) increased confidence in ability to verbally de-escalate an agitated patient in a safe and effective manner, 2) increase confidence in ability to maintain personal safety while in the presence of an agitated patient, and 3) increase confidence in ability to implement verbal de-escalation techniques when working with an agitated patient.

**Implementation of the Project**

**Phase one.** Phase one of the project saw to the creation of an educational training package for USF FNP students that consisted of three components: 1) participation in a live-action behavioral simulation scenario, 2) review of online educational module, and 3) post intervention debrief of simulation and knowledge discussion. The first component of the training package occurred on October 22, 2016. A live in-person verbal de-escalation simulation training was performed with one student from USF FNP cohort 6 and an experienced actor portraying a standard patient. The simulated aggressive patient scenario was designed to present a realistic
scenario in which the FNP student may encounter in the outpatient setting (Appendix L). The simulation was videotaped with the student’s consent per the USF simulation center’s release waiver as cohort 6 classmates, this author, and DNP committee chair observed the interaction via a live video feed.

In an effort to better assess the student’s baseline knowledge of verbal de-escalation techniques, the educational material was intentionally withheld until after participation in the live-action simulation. Immediately following completion of the simulation, USF FNP cohort 6 students were granted access to the verbal de-escalation online educational material through the USF Canvas portal. The online educational material focused on identifying common signs of agitation and discussed goals of the verbal de-escalation process in terms of preemptively managing behaviors that may escalate quickly and risk the provider’s health and safety. Special attention was given to emphasize the utilization of the 10 domains of de-escalation as outlined by the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup (Richmond et al., 2012) when caring for the agitated patient. The author then led a post-simulation debrief with cohort 6 students to reflect back on the scenario and the challenges that the participating student faced.

**Phase two.** Building on the knowledge gained through phase one, phase two implementation included the verbal de-escalation training of practicing clinicians and FNP students at the Native American Health Center in Oakland, CA. The tailored educational training package was presented to three practicing clinicians and three FNP students. A total of six pre-intervention survey questionnaires were distributed. Presentation of the educational material via a PowerPoint slide-deck was met with great response. Following presentation of the educational material, participants were shown the previously recorded USF student simulation
scenario. A discussion ensued highlighting the challenges that the FNP student faced and questions were posed to stimulate thought as to how verbal de-escalation techniques could have been applied to the scenario. Upon completion of the training, six post-training questionnaires were distributed and returned. Survey results were collected and saved for future analysis.

**Phase three.** On March 24th, the verbal de-escalation training package was presented to seven DNP/FNP students and two FNP/Faculty at the March Lunch and Learn event at USF. The educational training included the same pre/post intervention survey questionnaire, PowerPoint presentation entitled “Risky Business: Verbal De-escalation of the Agitated Patient for the Family Nurse Practitioner,” and presentation of the previously recorded USF student simulation video. Again, a discussion ensued that served to stimulate a conversation surrounding the challenges faced by outpatient FNPs when working with an agitated patient. Upon completion of the educational training, seven post-survey questionnaires were distributed, completed, and returned. Survey results were collected and saved for future analysis.

**Methods of Evaluation**

In order to study intended outcomes, focus was directed at examining a change in confidence to better identify the relevancy and applicability of verbal de-escalation teachings found within this project. The outcomes selected for measurement were based on the five questions asked in the pre/post intervention survey questionnaire: 1) frequency of interactions with agitated patients, 2) confidence in ability to verbally de-escalate an agitated patient in a safe and effective manner, 3) confidence in ability to maintain my personal safety while in the presence of an agitated patient 4) having received adequate education on how to safely and effectively verbally de-escalate an aggressive patient, and 5) confidence in ability to implement verbal de-escalation techniques when working with an agitated patient. These five questions
were graded on a 5-point Likert-type scale with 1 being strongly disagree and 5 being strongly agree.

Prior to completing the data analysis, it was expected that there would be an increase in confidence in incorporating verbal de-escalation techniques into practice. This method of evaluation was created to determine if the educational material was effective in increasing provider confidence of verbal de-escalation techniques. However, it is important to note that this evaluation method does not assess for adherence in practice or long-term knowledge retention.

Analysis

Survey data was entered into tabular format for ordinal data analysis using Google Sheets. The five confidence-based survey questions were graded on a 5-point Likert-type scale, with 1 being “strongly disagree” and 5 being “strongly agree”. The mean response values were calculated for both the pre and post intervention questionnaires to summarize the central tendency for each survey item. The data was further broken down by role (FNP student and FNP clinician). The percent change (delta Δ) was then calculated to summarize the pre-post shift in mean response values. Paired column charts were then generated to assist with visualizing the data.

SECTION IV: Results

Simulation Evaluation

During the post simulation debrief with cohort 6, students were asked to discuss past experiences with agitated patients, describe baseline knowledge of verbal de-escalation, and current comfort level in caring for agitated patients. An interesting and insightful conversation ensued in which the consensus was that if the students felt threatened in the outpatient setting they would call for the help of a supervisor or flee the situation entirely. This is not a surprising
response considering the majority of the cohort 6 students had previous experience as inpatient Registered Nurses (RN) at large academic institutions in the Bay Area. When faced with an agitated patient as an RN in an inpatient environment with superior resources, you are expected to maintain your safety by removing yourself from danger, notify the physician, and call security. Three students immediately spoke out saying that based on their past experiences working in the Emergency Department, they would want to medicate/sedate, restrain, and seclude the agitated patient. The participating student with a background in home healthcare verbalized that she did not feel comfortable at all during the simulation. She discussed feelings of wanting to remove herself from the scenario in order to maintain her safety. A student with previous experience as a psychiatric RN spoke up against her classmates by saying “I was unaware of these domains of de-escalation, but over the years I have incorporated these themes into my practice and they really do help to calm a patient before violence is met.” Being mindful of these varying thoughts and emotions, this author concluded the discussion by posing a question for reflection: What happens if you are now in a small outpatient clinic, alone, or working as the supervising provider; what would you do? Would you still choose to flee the scene?

Survey Evaluation

As of March 2017, a total of 14 participants were presented the educational intervention which included a PowerPoint presentation, viewing of the previously recorded simulation scenario, and completion of a pre-post intervention survey questionnaire. Of those 14 participants, 10 were FNP students in their final semester of graduate school, and 4 were practicing FNP clinicians with varying years of experience.
Analysis of the pre-post educational intervention data is displayed in tables (see Appendix O). Question 1 of the survey indicted a negligible increase, 3.2 to 3.3, which was to be expected given the nature of the question, “I frequently interact with agitated patients.” Question 2 of the survey, “I am confident in my ability to verbally de-escalate an agitated patient in a safe and effective manner,” demonstrated a 65% increase in confidence from 2.5 to 4.1. Question 3, “I am confident in my ability to maintain my personal safety while in the presence of an agitated patient,” showed a 40.4% increase from 3.0 to 4.2. It was encouraging to note these results and see that students and providers felt as if they could maintain their safety despite undercurrents of discomfort and fear when caring for agitated patients. Analysis of question 4, “I have received adequate education on how to safely and effectively verbally de-escalate an agitated patient” produced the largest increase in pre-post shift. Initial pre- intervention results revealed the staggeringly low mean response value of 1.7. Post- intervention results dramatically increased to 4.2. Question 5, “I am confident in my ability to implement verbal de-escalation techniques when working with an agitated patient,” also revealed a dramatic pre-post shift increase from 2.0 to 4.3. The 136% increase seen with question 4 and the 117% increase with question 5 only helped to further validate the need for targeted verbal de-escalation training to both students and practicing clinicians.

SECTION V: Discussion

Summary

While there were some minor variances amongst the surveyed students and practicing clinicians, generally speaking, results of the data analysis indicated that the educational intervention did lead to increased confidence in participants’ ability to utilize verbal de-escalation techniques when working with an agitated patient (Appendix O). Overall, the
educational intervention was well-received by all participants and stimulated thoughtful discussion. A suggestion for future consideration that came up during these discussions was a request for the development of a pocket-sized card with the 10 domains of verbal de-escalation listed in a bullet point format. Additional comments relayed by the intervention participants included, “can this please be incorporated into our standard curriculum.” “Simple and to the point.” “These are some great simple tips that I can use for all patients, not just the agitated ones.”

Of the key findings revealed by this project, most important is the significant lack of verbal de-escalation training in current FNP educational curriculum. Data analysis demonstrated that of the surveyed participants, all of them either “disagreed” or “strongly disagreed” with the statement “I have received adequate education on how to safely and effectively verbally de-escalate an agitated patient.” The dramatic increase in confidence with this statement following the educational intervention demonstrates that the students and clinicians are open and receptive to the topic. Results indicate that all FNP students and FNP clinicians would likely benefit from recurring formal verbal de-escalation training whether it be provided in the academic or occupational setting.

As revealed by the positive reactions and results of the survey responses, the implementation of this project was deemed to be successful in increasing provider confidence with the care of agitated patients in the outpatient setting. The success of this project highlights the often overlooked, yet critically important topic of how providers can successfully manage agitation in the outpatient setting. This is important to consider given the high rate of provider burnout often associated with frequent care of agitated patients (Richmond et al. 2012). Fiscally responsible leaders acknowledge that it is essential to be mindful of the high costs associated
with the replacement of a high-performing FNP who has chosen to leave a practice due to burnout. Given the high costs associated with the loss of productivity that accompany recruitment, orientation, and gradual onboarding of a newly hired FNP, a potential cost avoidance of $317,990 can be achieved by verbal de-escalation training.

In order to sustainably achieve the predicted outcomes of this project, FNPs will need frequent and recurrent verbal de-escalation education and training. As of March 2017, there have been some discussions amongst this author and USF faculty to incorporate verbal de-escalation training into the FNP curriculum. However, further discussion with key USF stakeholders will need to occur before a final decision can be made to move forward with a verbal de-escalation curriculum development plan.

Interpretation

The anticipated outcome of this project was that the educational intervention would increase FNP confidence in safely and effectively managing the behavior of an agitated patient. Results of this project met similar conclusions outlined by previous studies identified in the literature. Based on study findings that indicate almost all primary care providers will be met with some form of aggressive behaviors during the course of their careers, Vorderwulbecke et al. (2015) concluded that it is highly advisable to integrate aggression management education into standard medical training. The pre-post intervention survey again revealed similar results, indicating that all of the participants had encountered some form of agitation in the clinical setting.

Nau et al. (2009) came to an intriguing conclusion based on their study findings; stating it is reckless to assume that healthcare providers will learn aggression management on the job. They insist that formal de-escalation training is needed in order to improve comfort and
performance so they can effectively de-escalate and agitated patient. Pre-post intervention survey results support this statement, especially when analyzing data provided by the practicing FNP. While the clinicians presented with varying degrees of clinical experience, all of them did report an increase in comfort following the educational intervention.

Reflecting back on the available literary evidence and the positive outcomes of the project, it is apparent that healthcare associated workplace violence is a complex issue that requires careful attention. Although, as Zarola and Leather (2006) suggest, it is not a question of whether or not de-escalation training should be provided, but does the chosen modality actually improve clinical outcomes. The answer to that question lies beyond the scope of this limited project, but is important to ponder when considering the potential future place verbal de-escalation training may hold in FNP curriculum.

**Barriers and Limitations**

Even the best laid plans often go awry. As part of the project development phase, an attempt was made to identify potential threats and barriers to the project in order to minimize their effect on overall success and long term sustainability. As with most projects aimed to change practice, the area of greatest concern to this author was obtaining adequate stakeholder buy-in. By highlighting educational gaps in Family Nurse Practitioner education, this author ran the risk of alienating identified stakeholders by drawing attention to their limitations. Fortunately, USF faculty, FNP students, and practicing FNPs demonstrated unyielding support of the interventions proposed by this project and voice value in its anticipated outcomes. USF is applauded for their dedication to ensuring FNP students are given the tools necessary to safely function to the full extent of their license and are fully committed to working with FNP students to close any knowledge gaps that may negatively impact their safety as future practicing FNPs.
The resultant small sample size of the participant pool was an unexpected barrier that this author unfortunately encountered. The initial estimate for the participant pool was 30 FNP students and 10 FNP clinicians. However, due to unforeseen last minute schedule changes, only a total of 10 FNP students and 4 FNP clinicians were able to participate in the educational intervention.

Prior to implementation, it was also anticipated that this author would face challenges with evaluating the project’s long-term impact on practice change. Given the intrinsic nature of the project, this author was only able to assess for immediate post-intervention changes.

As with any new educational project, the successful implementation of this project faced its fair share of challenges. Overcoming those difficulties undoubtedly proved to be a worthwhile endeavor given the opportunities offered by this project. With the current state of healthcare, providers are forced into positions of increasing their total patient load, reducing the amount of time spent with each patient, and taking on increasingly complex patient case loads. Not surprisingly, these external stressors have led to an increased rate of burnout which leaves the overworked provider to seek the “quick” solution that feeds into negative behavior when dealing with the agitated patient. This approach does nothing but reinforce the patient’s thought process that violence is necessary in order to resolve conflict (Richmond et al. 2012). It is important that providers understand that these methods should not be a first line of defense against the behaviorally challenging patient and that verbal de-escalation is not the time-consuming process that many assume it to be. The successful implementation and evaluation of this project will only serve to add to the literature as a means of ensuring that verbal de-escalation education is taught not only to student FNPs, but to all student healthcare providers.
Conclusion

The Bureau of Labor and Statistics has identified healthcare as one of the most dangerous fields in the country (OSHA, 2013). In order to provide optimal quality healthcare, Providers deserve to be armed with the tools necessary to protect themselves from potentially dangerous interactions with agitated or aggressive patients regardless of the environment and in which they work.

Providers are seen as leaders of their microsystems and are often expected to know how to successfully manage aggressive patient behaviors. Providing verbal de-escalation education to FNP students and FNP clinicians is a small yet important step down the long road towards reducing workplace violence in the healthcare setting.

SECTION VI: Other Information

Funding

There was no identified need for outside funding of this project. The costs of this project were incorporated into preexisting organizational budgets. The DNP student did not receive any compensation for time spent planning, implementing, or evaluating the project.
SECTION VII: References


http://www.hopkinsmedicine.org/institute_nursing/continuing_education/ebp/ebp_books_consultations.html


http://www.modernhealthcare.com/article/20130810/MAGAZINE/308109974


managers: a national evaluation of the training provision in healthcare settings.

University of Nottingham, Suffolk. Retrieved from

To Whom It May Concern:  

August 24, 2016

This letter is to affirm support for the use of the USF Simulation Lab during the Assessment and Differential Diagnosis course for NP students, N735. Rachael Misitano, the DNP student has my permission to use the simulation laboratory spaces to conduct her DNP project intervention Evidence-Based Verbal De-escalation Techniques for the Family Nurse Practitioner: Education and Simulation. She will schedule this intervention with me at a mutually agreed upon time during the class meeting.

Sincerely,

Jo

Jo Loomis, DNP, FNP, CHSE
Assistant Professor
University of San Francisco
School of Nursing and Health Professions
Appendix B: Letter of Approval (NAHC)

February 2, 2017

To Whom It May Concern,

This letter grants approval for Rachael Misltano to implement her DNP project at Native American Health Center (NAHC) Oakland. We grant her permission to use the name of our agency for her DNP project intervention titled Evidence-Based Verbal De-escalation Techniques for the Family Nurse Practitioner: Education and Simulation.

Sincerely,

Christopher Balkissoon, FNP-C, MSN, RN
Appendix C: Johns Hopkins Nursing Evidence-Based Practice Rating Scale

### JHNEBP Evidence Rating Scales

#### Strength of the Evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Experimental study/randomized controlled trial (RCT) or meta analysis of RCT</td>
</tr>
<tr>
<td>II</td>
<td>Quasi-experimental study</td>
</tr>
<tr>
<td>III</td>
<td>Non-experimental study, qualitative study, or meta-synthesis.</td>
</tr>
<tr>
<td>IV</td>
<td>Opinion of nationally recognized experts based on research evidence or expert consensus panel (systematic review; clinical practice guidelines)</td>
</tr>
<tr>
<td>V</td>
<td>Opinion of individual expert based on non-research evidence. (Includes case studies; literature review; organizational experience e.g., quality improvement and financial data; clinical expertise, or personal experience)</td>
</tr>
</tbody>
</table>

#### Quality of the Evidence

<table>
<thead>
<tr>
<th>A</th>
<th>High</th>
<th>Research</th>
<th>Consistent results with sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Summative reviews</td>
<td>Well-defined, reproducible search strategies; consistent results with sufficient numbers of well-defined studies; criteria-based evaluation of overall scientific strength and quality of included studies; definitive conclusions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organizational</td>
<td>Well-defined methods using a rigorous approach; consistent results with sufficient sample size; use of reliable and valid measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expert Opinion</td>
<td>Expertise is clearly evident</td>
</tr>
<tr>
<td>B</td>
<td>Good</td>
<td>Research</td>
<td>Reasonably consistent results, sufficient sample size, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Summative reviews</td>
<td>Reasonably thorough and appropriate search; reasonably consistent results with sufficient numbers of well-defined studies; evaluation of strengths and limitations of included studies; fairly definitive conclusions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organizational</td>
<td>Well-defined methods; reasonably consistent results with sufficient numbers; use of reliable and valid measures; reasonably consistent recommendations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expert Opinion</td>
<td>Expertise appears to be credible</td>
</tr>
<tr>
<td>C</td>
<td>Low quality or major flaws</td>
<td>Research</td>
<td>Little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Summative reviews</td>
<td>Undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results; conclusions cannot be drawn</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organizational</td>
<td>Undefined, or poorly defined methods; insufficient sample size; inconsistent results; undefined, poorly defined or measures that lack adequate reliability or validity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expert Opinion</td>
<td>Expertise is not discernable or is dubious</td>
</tr>
</tbody>
</table>

*A study rated an A would be of high quality, whereas, a study rated a C would have major flaws that raise serious questions about the believability of the findings and should be automatically eliminated from consideration.*


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## Appendix D: Literary Evaluation Table

<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Year</th>
<th>Study Aim</th>
<th>Study Participants</th>
<th>Evaluation Methods</th>
<th>Outcomes</th>
<th>Level of Evidence</th>
</tr>
</thead>
</table>
| Duxbury, J. & Whittington, R. | 2005 | ▪ Compare patient and staff views about causes of aggression on mental health wards  
▪ Explore perspectives on existing management approaches | ▪ Patients (n=82) and Nurses (n=80) from 3 mental health wards  
▪ Male patients (n=40), female patients (n=42)  
▪ Female nurses (n=61), male nurses (n=19) | *Phase 1: MAVAS questionnaire survey*  
▪ Postal method for staff  
▪ Direct 1:1 administration with patients  
*Phase 2: semi-structured interviews*  
▪ Administered to subsample of respondents (staff and patients)  
▪ Open ended questions to clarify MAVAS  
▪ Recorded and transcribed | Causes of patient aggression  
▪ Internal factors  
▪ External factors  
▪ Interactional/situational factors  
Management  
▪ Respondents agree could be improved on  
▪ Medication and seclusion supported by staff, but opposed by patients  
▪ Training in the use of therapeutic communication skills was requested by patients | III/B |
| Nau et al. | 2009 | Develop and test a scale (DABS) to measure nursing students’ performance in de-escalation of aggressive behavior | Nursing students (n=105)  
▪ 7 themes of de-escalation behavior identified and wording of items tested  
▪ Students completed scale after watching a fellow student de-escalate simulated pts |  
▪ 7 items showed good internal consistency  
▪ DABS reliably able to measure nursing students’ performance in managing aggressive behavior  
▪ DABS may be a useful tool for training evaluation | III/B |
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Study Description</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nau et al.</td>
<td>2009</td>
<td>Examine the influence of aggression management training for nursing students on de-escalation performance</td>
<td>Nursing students (n=78)</td>
<td>Cross sectional and longitudinal groups Students encountered two scenarios (A,B) with simulated patients After completing de-escalation training, each student encountered opposite (unknown) scenario De-escalation experts reviewed video tapes and scored students using DABS Using DABS, students performed better (2.74-3.65) following de-escalation training No significant difference found in pretest results irrespective of students’ age or level of nursing education</td>
</tr>
<tr>
<td>Richmond et al.</td>
<td>2011</td>
<td>Expert consensus statement detailing the foundations for training for de-escalation</td>
<td>N/A</td>
<td>Acute agitation requires immediate intervention Restraints and involuntary medicine should be replaced with noncoercive measures (verbal de-escalation) 3 step approach: verbally engage, establish collaborative relationship, de-escalate patient Expert guidelines for 10 domains of de-escalation</td>
</tr>
<tr>
<td>Price, O. &amp; Baker, J.</td>
<td>2012</td>
<td>Thematic synthesis literary review</td>
<td>Literary review of 11 international papers</td>
<td>7 de-escalation themes identified Characteristics of effective de-escalators Maintaining personal control Verbal and non-verbal skills Engaging with the patient When to intervene Ensuring safe conditions for de-escalation Strategies for de-escalation</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Study Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| AbuAlRub, R. & Khawaldeh, A. | 2013 | - Examine incidence, frequency, and contributing factors to workplace violence among nurses and physician  
- Identify existing policies and management modalities to address workplace violence  
- Jordanian physician (n=125)  
- Jordanian nurses (n=396)  
- Working in underserved hospitals  
- Descriptive exploratory research design  
- Questionnaire developed by WHO, ILO, and ICN  
- 15% of participants exposed to physical violence  
- Contributing factors included lack of policies, inadequate staffing, lack of communication skills  
- Respondents requesting strengthened security and education/training for decreasing violence |
| Vorderwulbecke et al.      | 2015 | - Contribute to and improve current data regarding issues of aggression and violence against primary care providers in Germany  
- Primary care providers in Germany  
- 835 completed questionnaires returned (out of 1500)  
- One time postal questionnaire sent to random sample of 1500 primary care providers  
- Four page questionnaire with questions about type, frequency, severity, and site of aggressive behavior against physician  
- 91% reported being the object of aggressive behavior at some point in career  
- 73% experienced aggression within the preceding 12 months  
- 23% experienced severe aggression in entire career  
- 11% experienced severe aggression in preceding 12 months  
- Almost every physician surveyed had experienced some form of aggression at some point in career  
- Advisable to introduce information on how to manage aggressive behaviors into medication education and continuing medical education |
| Mavandadi, Bieling, & Madsen | 2016 | Elaborate on DABS and enhance to become EMDABS | ▪ Video simulations taken from a 3-year workforce initiative to assess and improve de-escalation skills  
▪ Develop item descriptions for EMDABs  
▪ Review of video simulations using EMDABS tool | ▪ EMDABS showed good inter-rater reliability and strong internal consistency  
▪ EMDABS validated for future use in research and practice  
▪ EMDABS seven item evaluation have clinical implications for improving practice and training | III/B |
Appendix E: Maslow’s Hierarchy of Needs

- **Physiological needs:**
  - food, water, warmth, rest

- **Safety needs:**
  - security, safety

- **Belongingness and love needs:**
  - intimate relationships, friends

- **Esteem needs:**
  - prestige and feeling of accomplishment

- **Self-actualization:**
  - achieving one’s full potential, including creative activities

**Basic needs:**

- **Self-fulfillment needs:**

**Psychological needs:**

- Competence, Approval, Status, Sense of Achievement
- Mutual Social & Intimate Relationships: Membership
- Stability, Safety in family, society, & one’s organization
- Wisdom, Discernment, Understanding, and Context for Life; Self-fulfillment that can lead to a new focus on helping others (but not necessarily).
## Appendix F: Gap Analysis

### University of San Francisco (USF)

<table>
<thead>
<tr>
<th>Current State</th>
<th>Best Practice</th>
<th>Proposed Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absence of verbal de-escalation training in current USF FNP curriculum</td>
<td>Recommend verbal de-escalation techniques be incorporated into provider (MD, NP, PA) curriculum</td>
<td>Incorporation of verbal de-escalation training into USF FNP curriculum through online learning modules and live-action simulation</td>
</tr>
<tr>
<td>Absence of education regarding the management of agitated, hostile, and assaultive behaviors in current USF FNP curriculum</td>
<td>Recommend verbal de-escalation techniques be incorporated into provider (MD, NP, PA) curriculum</td>
<td>Incorporation of verbal de-escalation training into USF FNP curriculum through online learning modules and live-action simulation</td>
</tr>
<tr>
<td>USF FNP students complete current course requirements without feeling sufficiently prepared to manage the behaviors of an acutely agitated patient</td>
<td>Recommend verbal de-escalation techniques be incorporated into provider (MD, NP, PA) curriculum</td>
<td>Incorporation of verbal de-escalation training into USF FNP curriculum through online learning modules and live-action simulation</td>
</tr>
</tbody>
</table>

### Native American Health Center (NAHC)

<table>
<thead>
<tr>
<th>Current Practice/Current State</th>
<th>Best Practice</th>
<th>Proposed Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistent approach to the management of the agitated patients in an outpatient setting</td>
<td>Incorporate a systematic approach using Project BETA’s 10 domains of de-escalation into practice</td>
<td>Provide education to practicing FNPs and student FNP students on the systematic use of Project BETA’s 10 domains of de-escalation</td>
</tr>
<tr>
<td>Primary care providers are likely to experience directed aggression from agitated patients at some point in their careers</td>
<td>Continuing education for verbal de-escalation should be provided to all primary care providers</td>
<td>Provide education to practicing FNPs on how to verbally de-escalate an agitated patient</td>
</tr>
<tr>
<td>Utilization of coercive measures to calm an agitated patient</td>
<td>AAEP advocates for utilization of verbal de-escalation techniques instead of coercive measures such as restraints, medications, and seclusion</td>
<td>Provide education to practicing FNPs and FNP students on ease of verbal de-escalation techniques and present evidence demonstrating the negative effects of coercive measures</td>
</tr>
</tbody>
</table>
Appendix G: Work Breakdown Structure
## Appendix H: GANTT Chart

<table>
<thead>
<tr>
<th>Course</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May</td>
<td>Jun</td>
</tr>
<tr>
<td><strong>DEVELOPMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macrosystem Assessment - Project Identification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literature Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gap Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Goal Setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop Implementation Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit Prospectus (Quals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit Manuscript (Quals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refine Implementation Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of online educational training module</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sim scenario development, find &amp; collaborate with actor</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMPLEMENTATION (Phase 1)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live-action simulation with USF FNP students (Cohort 6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online education module presented to USF FNP students (Cohort 6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Simulation debrief</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMPLEMENTATION (Phase 2)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational training presented to NAHC compliance officer for review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre/post training Survey Created</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational training presented to NAHC staff (pre/post survey)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMPLEMENTATION (Phase 3)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational training presented to USF students/faculty at Lunch and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learn, (pre/post survey)</td>
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<td></td>
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<tr>
<td><strong>EVALUATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey Collection and Evaluation</td>
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<tr>
<td>Phase 1 Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 2 Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 3 Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propose expansion of education/training to additional clinic sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begin final write-up</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix I: SWOT Analysis

### Strengths
- FNP driven
- Evidence-based
- FNP dedicated to promoting provider safety and improving patient outcomes
- Proactive patient care planning
- Better utilization of resources
- Fosters provider safety
- De-escalation encourages patients to become active participants in their plan of care

### Weaknesses
- Difficult to collect long-term efficacy data
- Majority of providers at NAHC speak English
- Large portion of NAHC patient population speaks Spanish
- Many clinicians do not feel prepared to address supportive care needs or psychosocial issues
- Busy work environments

### Opportunities
- To identify and address comprehensive psychosocial needs early
- Empower providers to advocate for patient safety
- Empower providers to advocate for staff safety
- Provide real time de-escalation role modeling to ancillary staff
- Improve care provided to psychiatric patients in non-psychiatric settings
- Enhance rapport and communication between patients and clinicians

### Threats
- Inadequate stakeholder buy-in
- Potential unforeseen interferences with daily workflow
- Lack of clinician engagement
- Misconceptions and misunderstanding of the needs of the agitated patient
- Fear and anxiety
- On site security at NAHC
Appendix J: Cost-Benefit Analysis

<table>
<thead>
<tr>
<th>Direct Expenses</th>
<th>Projected</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of Training Package: NP hrs @ $50/hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creation of online education module: 10 hrs</td>
<td>500.00</td>
<td>0.00 (In Kind)</td>
</tr>
<tr>
<td>Creation of live simulation scenario: 10 hrs</td>
<td>500.00</td>
<td>0.00 (In Kind)</td>
</tr>
<tr>
<td>Creation of online surveys: 5 hrs</td>
<td>250.00</td>
<td>0.00 (In Kind)</td>
</tr>
<tr>
<td>Standard Patient: Compensation @ $50/hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration with Standard Patient: 2 hrs</td>
<td>$100.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>Simulation Scenario: NP and SP @ $50/hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of simulation scenario at USF: 2 hrs</td>
<td>$100.00</td>
<td>0.00 (In Kind)</td>
</tr>
<tr>
<td>Travel: @$20/hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent traveling to USF and NAHC: 4 hrs</td>
<td>$40.00</td>
<td>0.00 (In Kind)</td>
</tr>
<tr>
<td>Parking at USF: 2 hrs</td>
<td>$20.00</td>
<td>0.00 (In Kind)</td>
</tr>
<tr>
<td>Subtotal Direct Expenses</td>
<td>$1510 (Projected)</td>
<td>$100 (Actual)</td>
</tr>
</tbody>
</table>

Cost Avoidance

Nurse Practitioner salary + onboarding                                           | $319,500.00 |

Project Direct Expenses                                                          | $1510 (projected) | $100 (Actual) |

Potential Cost Avoidance of Project (per FNP)                                    | $317,990.00 | $319,400.00 |
Appendix K: Communication Matrix

Author
Rachael Misitano

DNP Chair
Dr. Jo Loomis
(Email, in person, phone as needed)

Co-chair Dr. Robin Buccheri
(Email as needed)

Project Implementation Sites

USF Simulation Lab
(Dr. Jo Loomis)

NAHC Oakland
(Chris Balkissoon, FNP)

USF Lunch and Learn
(Dr. Prabjot Sandhu)
Appendix L: Simulation Scenario

PATIENT HISTORY
John is a 50 year old male with a history of a severe traumatic brain injury 5 years ago when he was involved in a motor vehicle accident in which he suffered multiple contusions and skull fractures. John has since physically recovered from the accident however, he now suffers from short term memory loss, insomnia, inability to maintain focus/concentration, and chronic debilitating headaches and generalized pain.

CHIEF COMPLAINT
“Medication refill”

SCENARIO
It is 6:00pm on a Friday night. Your clinic usually sees their last patient at 5:30pm but you decide to stay late to see a colleague’s patient who had been bumped from his appointment for the past 2 days due to overbookings. Your medical assistants have been working late every day this week so you decide to send them home early as soon as they have roomed the patient. You see that he is only here for a medication refill. It’s only 1 more patient, should be a quick visit, you can handle that right?

Right before your MA leaves, she reminds you that this patient has a pain contract with your physician colleague and that she ran a urine drug screen (clinic policy) and it tested (+) cocaine. Per the pain contract, recreational drugs such as cocaine are not allowed and may result in termination of the provider/patient relationship.

You enter the exam room and notice that the patient is pacing the room and appears visibly upset. He is wringing his hands and pacing up and down. Before you say anything, he verbally erupts and begins demanding an explanation as to why his appointment was cancelled two days in a row. “I ran out of my Norco last week, my pain is out of control and your secretaries keep cancelling my appointments!” “I’m sick of dealing with you people, you need to fix this right now!”

How would you approach this situation? What would your next steps be? What types of de-escalation techniques would you consider using?

Case Study- Agitated Patient

Goal of Case Scenario:
• Successfully de-escalate an agitated patient
• Help the patient manage their emotion and distress to regain control of their behavior
• Ensure the safety of the patient and provider
Patient: John Boltin, 50 year old male

John is a 50 year old male with a history of a severe traumatic brain injury 5 years ago when he was involved in a motor vehicle accident in which he suffered multiple contusions and skull fractures. John has since physically recovered from the accident however, he now suffers from short term memory loss, insomnia, inability to maintain focus/concentration, and chronic debilitating headaches and generalized pain. In February John was involved in another minor MVA in which he was seen in the ED for “whiplash.” John reports increased musculoskeletal pain since. John also shares that on 4th of July weekend, he was attempting to carry a cooler in from the garage and slipped on some melted ice and fell on the cement floor. He reported hitting his head on the floor associated with a brief loss of consciousness. Since this event, his headaches and ability to focus have considerably worsened.

Chief complaint: “I need a refill of my medication”
Prep/Supplies Needed for Patient: None
Summary of patient’s chart:

<table>
<thead>
<tr>
<th>Past Medical/Surgical/OB/Psych Hx:</th>
<th>Allergies</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Severe traumatic brain injury in 2011 (MVA) with temporal skull fracture</td>
<td>NKDA, no environmental allergies</td>
<td>MGM Colon CA died age 70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social History</th>
<th>Tobacco:</th>
<th>Health Care Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet: Regular</td>
<td>occasional</td>
<td>Vaccinations: unsure</td>
</tr>
<tr>
<td>Exercise: no regular exercise regime</td>
<td>Drugs:</td>
<td>Screenings: unsure what he has had done</td>
</tr>
<tr>
<td>Interests/hobbies: hanging out with friends</td>
<td>marijuana</td>
<td></td>
</tr>
<tr>
<td>Housing situation: lives with wife and 2 sons</td>
<td>Alcohol:</td>
<td></td>
</tr>
<tr>
<td>Sexual history: monogamous with wife</td>
<td>3-4 beers every night</td>
<td></td>
</tr>
<tr>
<td>Education: High School dropout</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation: Construction worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/support: Close family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medication List:
- Hydrocodone-acetaminophen (Norco) 2 tablets every 6 hours PRN pain
- Gabapentin 300mg TID
- Nortiptyline 25mg daily
Instructions to Standardized Patient- *Story*

John was in a severe car accident 5 years ago that resulted in a 1 month hospital stay (2 weeks in ICU). He suffered multiple broken bones (arms/legs) and a severe temporal skull fracture that required brain surgery. John has since physically recovered from the accident however, he now suffers from short term memory loss, insomnia, inability to maintain focus/concentration, and chronic debilitating headaches and generalized pain. In February John was involved in another minor MVA in which he was seen in the ED for “whiplash.” John reports increased musculoskeletal pain in his neck since. John also shares that on 4th of July weekend, he was attempting to carry a cooler in from the garage and slipped on some melted ice and fell on the cement floor. He reported hitting his head on the floor associated with a brief loss of consciousness. He did go to the ER after this event and they gave him 30 tablets of Norco. Since this event, his headaches and ability to focus have considerably worsened.

- **Social history**
  - You live in Oakland with your wife and 3 sons (ages 5, 7, 10)
  - You used to be a carpenter, but now find it extremely difficult to consistently work
    - This is hard for you because you identify yourself as a craftsman
    - You often feel as if you are a burden on your family
  - Financially you and your family are struggling because you are unable to work

- **You have had a 10/10 headache since last night**
  - Nothing makes your headache better
  - Bright lights and noise seems to make it a little worse
  - You “took all your meds this morning” but can’t remember what the dosages were
  - You also took some tylenol and ibuprofen

- **You haven’t slept well since you accident**
  - Lately your sleep has worsened since the 4th of July accident
  - You have trouble falling asleep and wake up frequently throughout the night
  - Feel tired all the time

- **They should ask about cocaine use**
  - At first you really don’t remember taking it
  - If they press the issue, then elaborate that you were hanging out with a friend and told him you had a horrible headache and he gave you something that he said would help - you decided to take it because the pain was so bad and you had run out of your Norco
  - If they threaten to terminate you as a patient, use this opportunity to increase your agitation
  - You deny any other illicit drug use
• Hopefully the students will touch on possible underlying depression
  o They may ask questions based on the PHQ-9 depression screening questionnaire
  o In the past 2 weeks, how often have you been bothered by any of the following problems?
    ▪ Little Interest or pleasure in doing things (Yes, more than half the days)
    ▪ Feeling down, depressed, or hopeless (Yes, more than half the days)
    ▪ Trouble falling or staying asleep or sleeping too much (Yes, more than half the days)
    ▪ Feeling tired or having little energy (Yes, more than half the days)
    ▪ Poor appetite or overeating (Yes, several days)
    ▪ Feeling bad about yourself or that you are a failure or have let yourself or your family down (Yes, more than half the days)
    ▪ Trouble concentrating on things, such as reading the newspaper or watching television (Yes, nearly every day)
    ▪ Moving or speaking so slowly that other people could have noticed. Or the opposite of being so fidgety or restless that you have been moving around more than usual (Yes, feeling fidgety more than half the days)
    ▪ Thoughts that you would be better off dead or of hurting yourself (Yes, several days)
    ▪ Total score 17 = Moderately severe depression
• You are angry/frustrated that the clinic has cancelled your appointments and that you aren’t able to see your primary provider who knows your history and plan of care.
• You are very fidgety and find it difficult to sit still. Your mood fluctuates from projecting feelings of agitation to hopelessness to desperation

• Hopefully the students will be able to utilize the 10 domains of de-escalation to reduce your agitation and frustration

• 10 domains of verbal de-escalation:
  o Respect personal space
  o Do not be provocative
  o Establish verbal contact
  o Be concise
  o Identify wants and feelings
  o Listen closely to what the patient is saying
    • Agree or agree to disagree
    • Lay down the law and set clear limits
    • Offer choices and optimism
    • Debrief the patient and staff
VS: T 98.6, BP 145/82, R 20, P 90

Review Of Systems
Pertinent positives:
  Fatigue
  Headaches (10/10), recent head injury 3 months ago, occasional dizziness
  Posterior cervical neck pain
  Recent decrease in appetite - unsure if you have lost any weight
  Feelings of depression, anxiety associated with pain

Pertinent negatives:
  No vision changes - no double/blurry vision
  No difficulty breathing
  No chest pain
  No diarrhea
  No numbness or tingling in extremities
  No thoughts of self-harm, suicide, or homicide

Physical Examination
Patient is agitated and anxious, pacing the room, can’t sit still and wringing his hands. Refuses physical exam.

Differential Diagnoses and Debrief: Important Take-Home Points to discuss post case:

The real point of this simulation is to successfully de-escalate the agitated patient and identify a plan of care

Topics to discuss during debrief
- How many are currently working in a hospital setting?
- What do you do when you encounter an agitated patient? Who do you call?
- How many work in an outpatient setting? Does your clinic have security?
- What are you going to do when you are alone in a clinic and you are now the provider
- Remember the 10 domains of de-escalation
  o Respect personal space
  o Do not be provocative
  o Establish verbal contact
  o Be concise
  o Identify wants and feelings
  o Listen closely to what the patient is saying
  o Agree or agree to disagree
  o Lay down the law and set clear limits
  o Offer choices and optimism
  o Debrief the patient and staff
- Recognize your part in the situation - how are you portraying yourself
- When someone is escalated, they are not in learning mode - do not try to teach them anything! - wait until they are de-escalated
- Do not make assumptions
Appendix M: PowerPoint Slides

Risky Business: Verbal De-escalation of the Agitated Patient for the Family Nurse Practitioner

Rachael Misitano, MSN, RN, CNL, DNP(c)

Unfortunate reality

- Healthcare workers have one of the highest rates of nonfatal assault injuries in the workplace
- Healthcare providers are assaulted at a rate of 7.8 per 10,000 workers
  - Compared to the national average of 2.1 assaults per 10,000 workers found in a non-healthcare setting (%)
- In the emergency setting, 67% of nurses, 63% of nursing assistants, and 51% of MDs have been assaulted at least once in the previous 6 months by patients
- 29% of MDs have been victims of patient-driven aggression in the past month
- 8% reported being victims of serious physical violence and/or sexual assault

Objectives

- Identify and distinguish three different types of aggression commonly exhibited by agitated patients
- Identify Project BETA’s 10 domains of de-escalation of the agitated patient
- Construct an appropriate response to the care of the agitated patient by incorporating Project BETA’s 10 domains of de-escalation

German Study

- 91% of primary care physicians confronted with aggressive behaviors throughout their career
- 73% report the experience occurred within the preceding 12 months
- Female physicians (60%) were more likely to be subjected to aggressive behaviors than male physicians (91%)
- “Almost every surveyed physician had experienced aggression at some point in their career”

Agitated patients

When faced with the care of an agitated patient, it is critical to identify the type of aggression they may be presenting with in order to better understand the patient and manage their care.
Types of aggression

- Instrumental Aggression
- Irritable Aggression
- Fear Driven Aggression

Types of aggression

- Instrumental Aggression
  - People tend to get what they want by means of violence or threats of violence
  - Not driven by emotion
  - Handled by using unspecifed counter-offers to the aggressor's threat
- Sample interaction
  - "I'm going to hurt her if I don't get a cigarette" "I don't think that's a good idea"

Types of aggression

- Irritable Aggression (Type I)
  - Patient has boundaries that are violated
  - Cheated on, humiliated, emotionally wounded
  - Often angry and trying to regain self worth and integrity
  - Wants to be heard and have feelings validated
  - De-escalation achieved by
    - Setting conditions for patient to be heard
    - Break the record approach
    - Agree in principle that the patient's anger is justified
    - Tell patient you want to know more but cannot until he regains control so that we can talk
    - If patient thinks you don't understand, tell him "you may be right, but I want to try to understand"
    - May need to repeat this loop a dozen times before the patient complies

Types of aggression

- Irritable Aggression (Type II)
  - Occurs in people who are chronically angry at the world
  - Often looking for an excuse to pick a fight
  - Unable to give a reason for their anger
  - Makes unrealistic and erratic demands and uses them as an excuse to attack when demands are not met
  - De-escalate by...
    - Do not react in a startled or defensive way, patient looking for an emotional response
    - Don't give them an audience (remove all unnecessary staff and patients)
    - Use emotional responses
    - Give the patient choices other than violence to get what he wants
    - Use the broken record technique to return to options that you can offer
    - Convey that you are willing to work with him, but only when he is willing to cooperate
    - Set firm limits

Types of aggression

- Fear Driven Aggression
  - Patient wants to avoid being hurt and may attack to prevent someone from hurting him/her
  - Give the patient plenty of space
  - DO NOT have a show of force or aim to intimidate or threaten the patient
  - March the patient's pace until he can focus on what is being said rather than on his fear

How can we minimize aggression?

- In 2012, the American Association for Emergency Psychiatry prompted the creation of Project BETA (Best practices in Evaluation and Treatment of Agitation)

- Consensus guidelines aimed to supplement the limited availability of verbal de-escalation literature and bridge the gaps often found in provider education
**VERBAL DE-ESCALATION**

**Project BETA**

- Encompasses 10 domains of de-escalation designed to advocate for a more contemporary and non-coercive approach for providers to engage the patient, establish a collaborative relationship, and continue to verbally de-escalate the patient out of their agitated state.

- Aim to achieve 4 main objectives:
  - Ensure the safety of the patient, staff, and visitors
  - Help the patient manage their emotions and distress in order to better maintain control of their behavior
  - Avoid the use of restraints when at all possible
  - Avoid coercive interventions that escalate agitation

**Ten domains of de-escalation**

- Respect personal space
- Do not be provocative
- Establish verbal contact
- Be concise
- Identify wants and feelings
- Listen closely to what the patient is saying
- Agree or agree-to-disagree
- Lay down the law and set clear limits
- Offer choices and optimism
- Debrief the patient and staff

**Respect personal space**

- Normal eye contact
- Maintain at least 2x arm’s length distance
  - Expand that space if patient is severely agitated or paranoid
- Maintain an open path of exit

**Do not be provocative**

- Maintain a calm demeanor with relaxed facial expressions
- Be empathetic
- Convey genuine concern for the patient’s situation
- Be aware of your body language
  - Should be congruent with what you are saying
- Speak softly
- Avoid an angry or frustrated tone
- Maintain a relaxed stance
  - Arms uncrossed
  - Hands open
  - Knees bent
  - Hands visible and unclenched
- Avoid directly facing the patient
  - Stand at an angle so as not to appear confrontational

**Establish verbal contact**

- Introduce yourself
  - Who you are
  - What you are
- Verbalize that your goal is to keep them safe
- You will not allow harm
- You are there to help them regain control
- Last names vs. first names
- One Communicator
  - Avoid multiple communicators which can lead to confusion and further escalation
**Be concise**

- Use short phrases or sentences
- Use language that the patient will understand
  - Simple vocabulary
- Complex language can increase confusion and lead to escalation
- Repeat yourself
  - Essential when making requests of the patient, setting limits, and offering choices/alternatives

**Identify wants and feelings**

- Some patients only want to vent to an empathetic listener
- Ask the patient to specifically state what their request is
  - Regardless of your ability to fulfill it
- Simple statements
  - "I really need to know what you expected when you came here"
  - "Even if I can't provide it, I would like to know so we can work on it"
- Utilize "free information" to better identify wants and feelings
  - Trivial things the patient says
  - Body language
  - Past encounters with patient
- Recognizing free information allows the provider to respond empathetically and express a desire to help the patient get what they want

**Listen closely to what the patient is saying**

- Be an Active Listener
- Pay attention to what is being said
- Use clarifying statements, if needed
  - "Tell me if I have this right..."
- Be engaged in the conversation
  - Patient will recognize that you are there for them which will aid in fostering de-escalation
- Miller's Law
  - "To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of"

**Agree or agree to disagree**

- Agree with the patient as much as possible
- Fogging
  - Finding something about the patient's position with which you can agree with
- 3 ways of agreeing with a patient
  - Agree with the truth
  - Agree in principle
  - Agree with the odds
- Delusions
  - Acknowledge that you have never experienced what the patient is experiencing but that you believe he is having that experience
  - Agree to Disagree

**Lay down the law and set clear limits**

- Set limits
  - Demonstrate your intent to help, but not be abused
- Offer choices
- Propose alternatives
- Establish consequences
- Use positive reinforcement
- Communicate limits in a matter-of-fact way and not in a threatening manner
- Coach the patient in How to Stay in Control
  - "I really want you to sit down. When you pace, I feel frightened and I can't pay full attention to what you are saying. You can help me understand if you calmly tell me your concerns"
- Maintain "working conditions"
  - Mutual respect for each other

**Offer choices**

- When a patient has nothing left but to fight or flight, offering a choice can be a powerful tool
- Choice is often the only source of empowerment for the patient who believes physical violence is a necessary response
- Be assertive and quickly propose alternatives to violence
- Offer things that will be perceived as acts of kindness (blankets, magazines, access to phone, food, drinks)
- Choices must be realistic
- Never promise something that you cannot provide
  - Don't promise a chance to smoke when the hospital has a no smoking policy
**Broaching the subject of medications**

- When all attempts to verbally de-escalate fail, more coercive measures may need to be taken as a last resort
  - Restraints
  - Injectable medications
- The goal of medicating an agitated patient is to calm, **NOT** sedate
- When medications are indicated, offer choices to the patient
- Do not rush to give the medication, but be careful not to delay

**Optimism**

- Be optimistic and provide hope
- Let the patient know that they are safe and that you are there to help them regain control
- Give realistic time frames and agree to help the patient work on the problem
- For example, when a patient states: “I want to get out of here”
  
The provider can respond “I want that for you as well, I don’t want you to have to stay any longer than is necessary. How can we work together to help you get out of here?”

**Debrief the patient and staff**

- Debriefing is critical to restoring a therapeutic relationship between the patient and the provider
- The debriefing process
  - Explain why the intervention was necessary
  - Let the patient explain events from their perspective
  - Teach the patient how to request a “time out” and how to appropriately express their anger
  - Ask for feedback on whether the patient’s concerns were addressed
  - Help put the patient’s concerns into perspective
- Prevention is the best way to prevent agitation
  - “What would you do if you were very upset, like you were today? What can we do in the future to help you stay in control?”
- Don’t forget to debrief with all involved staff members
  - Address their concerns and recommend improvements for future episodes

**Recap: goals of treating agitation**

- Reduce distress, anger, and anguish
- Reduce and prevent dangerous behaviors
- Calm to tranquility without the intent to medicate or sedate
- Minimize the need for physical restraints
- Create a therapeutic alliance
- Collaborate to decrease future episodes of acute agitation

**Don’t Forget to CHART!**

- Be as detailed as you can
- If you utilized any of the 10 domains, discuss what worked and what didn’t
- An easy way to reinforce and teach de-escalation techniques to colleagues who may also see the patient

**Case scenario**

It is 7:00pm on a Friday night, you decide to stay late to see a colleague’s patient who has been bumped from his appointments for the past 2 days due to overbookings. Your medical assistants have worked late every day this week so you decide to send them home early. The patient is here for a medication refill, it should only take a few minutes and then you can head home after a long week.
You enter the exam room and immediately notice that the patient is wringing his hands, pacing the room, and appears visibly upset. Before you say anything, he verbally erupts and begins demanding an explanation as to why his appointment was canceled 2 days in a row.

"I ran out of my pain pills last week and I need a refill! My back pain is out of control and your secretaries keep cancelling my appointments!" "I'm sick of dealing with this, you need to fix this right now!"

This simple start to the conversation allows the provider to introduce themselves to the patient, establish verbal contact, and be concisely about the patient’s concerns in a non-threatening or provocative manner. Often times a calm and empathetic demeanor in combination with these techniques are enough to calm a patient.

"Hi Mr. Smith, my name is Kelly. I am a nurse practitioner who works with your primary care provider: Dr. Davis. I apologize that Dr. Davis is out of town this week, it sounds as if there was a mix up with your medication refill, I would like to hear more about it."

By communicating clear limits, asking what the specific problem is, and most importantly listening to what the patient has to say, the provider attempts to assist the patient by separating the emotional response from what it is they are truly seeking. At this point in the conversation you may have successfully calmed the patient and paved the way for more rational thought, or you may continue to struggle with the scenario.

"Mr. Smith, I know you are upset and in a lot of pain, but please stop shouting and have a seat. When you yell and swear, you upset other people around you and I can only work with you if you speak politely and respectfully. Tell me what the problem is and I will see what I can do to help you."

This never would have happened if your secretaries knew how to do their job! They are the ones that keep cancelling my appointments and putting me on hold for hours when I called to say I needed a refill."

Again, you may need to reorient the patient and reemphasize the limits you have already set during the conversation.

"Mr. Smith, I have looked through your medical history and read Dr. Davis’s last note about your most recent visit. It seems that you have a pain contract in place with him that prohibits any other providers from refilling or writing any narcotic prescriptions. Does that sound familiar to you? Good, I’m glad you remember that conversation, although unfortunately it doesn’t help us much right now."

"I recognize that you are hurting right now and I agree that you do need a refill on your medication, but because you have such a long history with Dr. Davis I do not feel comfortable going against the extensive plan that he has laid out for you. "I won’t be able to refill your prescription tonight, but I can offer you some alternative therapies that might ease the severity of your pain. Also, it looks as if Dr. Davis will be returning to the office tomorrow and if you are agreeable, I will give him a full update on how you are doing, and schedule an appointment with him first thing in the morning." "How does that sound to you?"

While it may be obvious as to what Mr. Smith’s response to the question will be, it is important to offer him a choice, no matter how small or trivial it may seem. Providers often forget how much control is taken away from our patients when we tell them to do A, B, and C, and to stop doing A, B, and C. Offering a choice will give him some control over a situation in which he likely feels helpless in.
References


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VERBAL DE-ESCALATION
Appendix N: Survey Questionnaires

Verbal De-escalation Pre-Intervention Survey

Please select one:  Student FNP _____  Practicing FNP _____

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<th>Question</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neutral (3)</th>
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<th>Strongly Agree (5)</th>
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<td>2. I am confident in my ability to verbally de-escalate an agitated</td>
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<td>patient in a safe and effective manner</td>
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<td>in the presence of an agitated patient</td>
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<td>4. I have received adequate education on how to safely and effectively</td>
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<td>verbally de-escalate an agitated patient</td>
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<td>5. I am confident in my ability to implement verbal de-escalation</td>
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<td>techniques when working with an agitated patient</td>
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Comments:
Verbal De-escalation Post-Intervention Survey

Please select one:  Student FNP _____  Practicing FNP _____

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<th>Disagree (2)</th>
<th>Neutral (3)</th>
<th>Agree (4)</th>
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<td>3. I am confident in my ability to maintain my personal safety while in the presence of an agitated patient</td>
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<td>5. I am confident in my ability to implement verbal de-escalation techniques when working with an agitated patient</td>
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Comments:
Appendix O: Pre-Post Intervention Survey Questionnaire Results
"I am confident in my ability to verbally de-escalate an agitated patient in a safe & effective manner"
"I am confident in my ability to maintain my personal safety while in the presence of an agitated patient"
"I have received adequate education on how to safely & effectively verbally de-escalate an aggressive patient"
"I am confident in my ability to implement verbal de-escalation techniques when working with an agitated patient."

- All: Pre 2.00, Post 4.36
- Student: Pre 2.00, Post 4.40
- FNP: Pre 2.00, Post 4.25

Question #5