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Program Evaluation of Prevention of Management of Disruptive Behavior-Military (PMDB-M) at Fort Bragg's Womack Army Medical Center (WAMC)

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Abstract

Project Title: Program Evaluation of Prevention of Management of Disruptive Behavior-Military (PMDB-M)

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Background or Problem/Issue: Healthcare providers (HCP) are the targets of workplace violence (WPV) at rates disproportionate to all but those employed in law enforcement, accounting for a staggering 75% of reported instances. The monetary cost of WPV within healthcare is estimated to be in the billions annually, while the physical and mental health and welfare of staff is degraded. The sequelae from WPV are vast and include increased rates of staff turnover, fatigue, elevated risks for medication errors, hospital acquired infections, and overall low patient satisfaction rates.

Clinical Question: Is the PMDB-M course effective in preparing healthcare workers to manage verbal and non-verbal conflict at Womack Army Medical Center?

Project Design: This program evaluation of PMDB-M was guided by the RE-AIM framework to determine the program's efficacy, implementation, and sustainability. The evaluation is informed by means of an electronic survey, mock code simulations using standardized patients (SP), and subjective interviews.

Data Analysis: Multiple descriptive statistics in concert with univariate and multivariate statistical analyses were employed to identify differences in perceived knowledge, skills, abilities, confidence, and preparedness between HCPs in different specialties, work areas, gender, age, and level of training. General perception of staff safety, violence reporting tendencies, and incidents of violence were analyzed.

Summary of Results: Mock code simulation participants (N=22) reported a statistically significant ($P<.05$) increase in perceived knowledge, confidence, and preparedness as measured in a validated tool administered prior to and following the simulation. In an electronic survey (N=191) respondents trained in PMDB-M reported a statistically significant increase in perceived knowledge, skill, ability, confidence, and preparedness as compared to respondents not trained in PMDB-M. Female survey respondents reported a statistically significant decrease in perceived skill, ability, confidence, and preparedness in managing violent behavior, though no difference in perceived knowledge between their male counterparts was detected.

Proposed Organizational Impact/Implications for Practice: Evaluating the DoD WPV program PMDB-M informs stakeholders of the program's effectiveness and sustainability. Evaluating the program elucidates opportunities for improvement, with the overall goal of decreasing rate of WPV, improving patient outcomes, and simultaneously protecting the organization from additional financial expense.

Keywords: Workplace Violence, Mock Codes, Simulation, Violence Prevention Programs

Program Evaluation of Prevention of Management of Disruptive Behavior-Military (PMDB-M) at Fort Bragg's Womack Army Medical Center

Healthcare workers (HCW) are frequent targets of workplace violence (WPV). In 2015 healthcare workers accounted for 75% of all reported incidents of WPV (The Joint Commission [TJC], 2018). The Occupational Safety and Health Administration (OSHA) reports that the prevalence rates for WPV perpetrated against HCWs is nearly four times higher than those employed in the private sector in non-healthcare related fields (2015). Further illustrating the disparity between HCW and non-HCW OSHA reports that even when the prevalence rates of WPV within construction, manufacturing, and retail trade are combined they are still less than those in the healthcare sector (2015).

Background

Despite an increase in the attention to and intolerance for violence in the United States in recent years, rates of WPV against HCWs and on-the-job injury rates attributable to these events continues to increase (Arnetz et al., 2014). Violence in healthcare has escalated to the point where TJC issued a "Sentinel Event Alert" in April of 2018, in which they warned healthcare institutions of the need for WPV prevention programs, such as the Department of Defense's Prevention and Management of the Disruptive Behavior - Military (PMDB-M). Although the risks for WPV across the spectrum of healthcare is diverse, both emergency department (ED) and inpatient psychiatric employees are currently identified as being the most vulnerable to violence in the workplace (TJC, 2018). Despite numerous studies highlighting the profound impact of workplace violence in the healthcare setting, prevention efforts remain inadequate (Gates et al., 2011).

The Human Cost of Workplace Violence

Acts of violence directed against physicians, social support staff, and patient care technicians are staggering (Gates et al., 2011). In the emergency department setting alone, one survey found that 67% of nurses, 63% of patient care technicians, and 51% of physicians had been physically or verbally "assaulted in the previous six months…by patients" (Gates et al., 2011, pp. 32-33). A 2014 survey of registered nurses (RN) and RN students by the American Nursing Association found that 21% of all survey respondents reported being physically assaulted, and 50% verbally assaulted in the preceding 12-month period (OSHA, 2015). Psychiatric technicians proved most vulnerable to violence with 590:10,000 employees suffering an injury requiring absence from work, as compared to nursing assistants at 55:10,000, and RNs at 14:10,000 (OSHA, 2015).

Within individual organizations, "employees affected by WPV expressed feeling angry, sad, depressed, anxious, and fearful. Additionally, they report meeting criteria for post-traumatic stress disorder and feel less safe and satisfied at work" (Gates et al., 2011, p. 33). The secondary and tertiary effects of violence against HCWs lead to increased staff turnover, fatigue, and elevated risks for medication errors and infections (OSHA, 2015); which in turn may lead to a decrease in overall patient satisfaction rates (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). These tangible effects, coupled with the TJC warning that violence against caregivers is "grossly underreported" (2018, p. 2), should alert installations within the Military Healthcare System (MHS) to the importance of continued efforts to effectively employ workplace violence prevention programs.

The Financial Cost of Workplace Violence

Some scholars estimate the costs associated with WPV aimed at HCWs to be in the range of billions of dollars annually (Papa & Venella, 2013). Costs associated with on-the-job injuries of HCWs are only surpassed by those in the law enforcement population (Lakatos et al., 2019), a truly alarming statistic. Although difficult to calculate on a per-event basis, there are certainly costs incurred as a result the sequelae of WPV to include the increased rates in medical errors, the cost of training new staff, and diminished patient satisfaction and overall outcomes (McHugh et al., 2011; OSHA, 2015).

National prevalence rates for violence against HCWs is 11.7 per 10,000 full-time equivalents (FTEs) worked, in stark comparison to 3.8 per 10,000 FTEs to employees in the private sector working non-healthcare related fields (Arnetz et al., 2014). Additionally, the rate of injury from WPV against HCWs is increasing disproportionately compared to those employees who work outside of healthcare (Arnetz et al., 2014), and underwent a "110% increase between 2005 and 2014" in private sector hospitals (Lakatos et al., 2019, p. 280). Focusing on quality workplace prevention programs to reduce the likelihood of healthcare workers incurring WPV related injuries can potentially yield cost savings for military treatment facilities (MTF).

Workplace Violence as a Threat to Mission Readiness

Violence, both physical and verbal, diminish HCWs' ability to perform their primary duty of optimizing the health of the force to protect mission readiness (Gates et al., 2015). Womack Army Medical Center (WAMC) supports all the tenant units on and around Fort Bragg, NC. These tenant units include the 82d Airborne Division, the XVIII Airborne Corps, and U.S. Special Forces (SF) school and multiple operational SF units. WAMC is charged with

maintaining the health of the largest military population in the world, ready to fight America's wars (WAMC, 2019). Any occurrences that reduce the installation's ability to wage war, including threats against medical readiness, should be taken seriously and with sufficient vigor to ensure appropriate mitigation.

Violence prevention programs are efficacious at reducing injuries by as much as 40% (Lakatos et al., 2019), while simultaneously increasing the reporting of violent events within the healthcare organization (TJC, 2018). The refinement of violence prevention methods found within PMDB-M are well suited for broad implementation across the MHS, and at a reduced cost (DeKunder, 2017). PMDB-M stands ready to increase the capability of WAMC to protect the readiness of local U.S. forces.

DOD Workplace Violence Prevention Program

Prevention and management of violent behavior training for HCWs is accepted as an efficacious modality in both the prevention and mitigation of incidents of violence in the healthcare setting. This training was first studied and reported to have positive effects within the Department of Veterans Affairs (VA) medical system in 1983 (Lehman, Padilla, Clark & Loucks, 1984). The WPV prevention program within the U.S. Military has since gone through a series of revisions to streamline the training program and increase its emphasis on verbal de-escalation techniques, relying on physical interventions only as the last course of action (DeKunder, 2017).

The current program, Prevention of Management of Disruptive Behavior-Military (PMDB-M), and its prioritization of de-escalation techniques, provides an evidence-based (Lehman et al., 1984; Hallett & Dickens, 2017; Lakatos et al., 2019) and easily trained solution capable of being employed across all of the branches of the U.S. military's combined medical

force (DeKunder, 2017). The PMDB-M program is currently mandatory training for all US Army employees working in the inpatient psychiatric environment (US Army Medical Command [MEDCOM], 2016). Before the Coronavirus-19 (CV19) pandemic, local leadership mandated PMDB-M training for all inpatient nursing and nursing support staff, however training was halted in response to pandemic safety guidelines resulting in only a small number of PMDB-M trained inpatient medical and surgical staff before January 2020 (V. Price, personal communication, September 1, 2020).

Clinical Question

Is the PMDB-M course effective in preparing healthcare workers to manage verbal and non-verbal conflict at Womack Army Medical Center?

Purpose of the Project / Project Aims

The focus of this project is a program evaluation to determine whether PMDB-M taught within WAMC's Department of Behavioral Health is a useful tool to increase staff perception of knowledge, skills, abilities, confidence, and preparedness (KSACP) as deemed necessary to de-escalate and mitigate violence in their workplaces. PMDB-M trained staff members will be evaluated for perceived KSACPs through surveys and simulated mock code scenarios involving actor portrayals of common disruptive events of a non-physical nature. Secondary focus areas will include evaluation of any actual or perceived barriers and unaddressed concerns of staff members through participant feedback and debriefings aimed to provide the command with feedback and if appropriate, actionable suggestions that may improve the program and implementation of PMDB-M.

Project Design

This program evaluation was guided by the Reach, Effectiveness, Adoption, Implementation, and Maintenance or RE-AIM framework (Glasgow, Vogt, & Boles, 1999) to determine PMDB-M's effectiveness and sustainability as a WPV prevention program. The evaluation involved three distinct arms, which in concert informed the parameters set forth in the RE-AIM model. The three arms were: (a) mock code de-escalation simulations; (b) electronic surveys; (c) subjective stakeholder interviews. Reach, Adoption, and Implementation were addressed primarily by subjective means in the form of interviews with key stakeholders within the organization along with surveys, while efficacy and implementation leveraged hands-on involvement from the project managers through facilitated mock code de-escalation simulations, feedback and debriefings. Maintenance was informed through data synthesis of all three arms, and powered the final recommendation based on the same with an emphasis on the future sustainability and implementation of PMDB-M.

General Approach

The authors will utilize mock code de-escalation simulations, electronic surveys, and subjective stakeholder interviews to obtain data meant to answer the clinical question, is PMDB-M efficacious at preventing and managing disruptive and violent behavior. The project will utilize a validated tool in a pre and post simulation survey format and embed it into the electronic survey to ascertain any effect on the clinical question. Electronic surveys will expand the data set to include a wider swath of the hospital to identify perceived KSACPs, WPV prevalence estimates, perceived safety, and reporting tendencies. Subjective stakeholder interviews will round the data set out and incorporate qualitative data of the same focus as the previous arms,

while also providing staff an opportunity to voice concerns over WPV and recommend any solutions they may have formulated.

Setting

As established previously, WPV is noted to have a detrimental effect throughout the hospital. As such, the setting of this program evaluation was broad and depended on each arm of the study. Volunteers for the mock code de-escalation simulations will be sought from the inpatient behavioral health unit as they are required by MEDCOM policy to receive PMDB-M training, as well as from the inpatient medical and surgical units, who only recently were required to receive the training by local leadership. This approach allowed the authors an opportunity to assess the perceived and demonstrated efficacy of PMDB-M training naturally without manipulation.

The electronic surveys would be focused primarily on garnering responses from staff members engaged in direct patient care, though responses from administrative and clinical support roles were also deemed valuable given the breadth of WPV. The structured interviews were targeted to answer specific RE-AIM questions including Reach, Adoption and Implementation but were also designed to allow the authors the ability to interact with front-line HCWs in their respective places of work so as to gain their perspective in a less structured format.

Procedural Steps

An overview of our project procedure is graphically depicted in Appendix E. WAMC's PMDB-M program evaluation began with engagement of the PMDB-M program manager and master trainers to inform RE-AIM, as well as to garner support for the evaluation. To evaluate Reach and Adoption, data was requested regarding the number of people in the target population,

and numbers trained. Non identifiable descriptive data on those previously trained in PMDB-M and those who undergo PMDB-M training during the project would be collected including, role and duty location, licensure, years in current role/overall experience, age, gender, and initial and recurrent PMDB-M training dates.

Shortly after initial interviews with PMDB-M facility experts, stakeholders were engaged in discussion to inform the project's intent, identify and mitigate any risks to the study, and obtain stakeholder buy-in. After stakeholders were informed, the proposed project plan was submitted to WAMC's Institutional Review Board for a non-research determination and approval as an evidence-based project (EBP) (Appendix B). Following non-research determination and approval as an EBP the authors proceeded with the program evaluation in the manner described herein.

Mock code de-escalation simulations. To evaluate the Effectiveness of PMDB-M training, as well as provide formative feedback on the program's Implementation and Maintenance, the authors designed mock code de-escalation scenarios utilizing standardized patients (SP)s for five-minute simulation encounters. These mock codes would be conducted with volunteer participants from inpatient behavioral health and inpatient medical/surgical care units, the former who were expected to be PMDB-M trained per MEDCOM policy with the latter likely to lack the training. The mock codes evaluated both the performance during the encounter, and the perceived KSACPs immediately prior to and following the simulation.

To evaluate performance, a key task checklist (Appendix C) was developed by the authors using the stated performance objectives and critical tasks outlined in the PMDB-M training material. The validated five question survey on learner's perceptions by Krull (Appendix D) and colleagues (2019) was utilized in a pre-post simulation format (Appendix E), and basic

demographic information was collected on each participant. The mock codes were designed not only to evaluate the PMDB-M program, but also as a platform to provide opportunity for participants to practice de-escalation techniques in a safe and controlled environment and enable feedback from PMDB-M facility trainers to address any gaps in knowledge and bolster safety.

The SPs for the mock codes consisted of three PMDB-M facility trainers, including one certified as master trainer and serves as the WAMC PMDB-M program manager. All facility trainers were certified through PMDB-M trainer training where they were taught to engage in clinical vignettes of a similar nature to the mock code de-escalation simulations, albeit shorter and less structured in format. Guidance from the National League of Nursing's (NLN) simulation design template and the International Nursing Association for Clinical Simulation and Learning (INACSL), as applicable to behavioral encounters, were utilized in conjunction with WAMC's clinical residency program simulation scenarios to create mock code scripts (INACSL, 2012; NLN, 2019).

Additional guidance from available simulation literature was utilized, leading to a prompt-response style of reaction to participant action/inaction during the scenario (Jeffries, 2005; Lazarra, Benishek, Dietz, Salas, & Adriansen, 2014). The authors sought out and incorporated suggestions from the PMDB-M facility trainers, as well as leadership in the respective sections wherein the encounters would take place to ensure the scenario was realistic and practical. This resulted in the development of two mock code simulation scripts (Appendix F) in which only certain details differed to enhance realism between the inpatient psychiatric and inpatient medical/surgical units. The mock code instructions, safety, and trigger warning briefings were identical between groups (Appendix G).

The PMDB-M facility trainers who agreed to participate as SPs in the project were involved in the development of the scenarios for the mock code de-escalation simulations to ensure both plausibility and reliability in grading. All three SPs were engaged in four training and validation sessions, during which each SP participated in the given scenario with both PMDB-M trained and untrained individuals. Both the authors and SPs observed these validation encounters and provided formative feedback to ensure each SP displayed mild, moderate, and severe levels of stress. Additionally, this was done to assure fidelity with the PMDB-M training material guidance (PMDB-M, 2019), repeatability between scenarios, and a manner that allowed participants sufficient time to demonstrate skills at each level of stress so they may be appropriately graded within the time of the simulation. When all of the SPs and the authors agreed the encounters were following the provided guidance with minimal deviation, and that the SPs could display each individual level of stress in a manner that could be recognized as such by the graders, it was determined that the simulations were adequately validated for the purposes of the project. Throughout the validation process, both of the project authors engaged in grading volunteers separately and would debrief on the individual grades following the encounter to ensure inter-rater reliability. It was agreed that the mean of both author's grades would be put forth for analysis at this junction.

The mock codes would occur in three settings, with two populations involved. Staff volunteering from inpatient behavioral health participated in the mock code de-escalation simulations in a conference room proximate to but not on the locked psychiatric ward in order to reduce disruption to patient care. Staff volunteering from the inpatient medical and surgical units participated in two different conference rooms adjacent their units, where patient care would not

be disrupted. All of the rooms for the simulations were cleared of as much furniture and debris as possible to maximize personal space on account of CV19 precautions.

Mock code de-escalation participants were briefed on the rules and guidelines of the encounter and read the scenario while standing outside and out of sight of the room in which the simulation would occur. Participants were asked to fill out the pre survey, after which they were given the chance to ask any questions they had about the upcoming simulation. The participants were instructed to knock and enter the simulation room, and the encounter began by them being engaged by the SP in accordance with the script. The SP displayed the varying levels of stress and responded to techniques and interventions appropriately, but in all cases would escalate to a higher level of stress. The SPs would escalate to the severe level of stress for a period of time that did not exceed 30 seconds and involved them closing the distance to the minimum of six feet often trying to walk around the participant to gain access to a notionally locked unit. The encounter was stopped by the evaluators when the participant took action to stop the patient, the SP had passed the participant, or at any time when the evaluators determined the minimum safe distance of six feet could no longer be obtained. The participant then completed the post survey before engaging in debriefing with the SP.

Electronic surveys. To inform Reach, Adoption, Implementation, and cultivate suggestions for Maintenance and future directions a 32-question electronic survey was created (Appendix H). The same validated five question tool utilized in the mock code de-escalation simulations in a pre-and-post format was embedded within this one-time survey to evaluate perceived KSACPs on a broader scale. The survey consisted of one filtering question to prevent repeat entries, ten questions on respondent demographics to include licensure, place of employment, degree of direct patient care, determination of day/night shift, six questions on the

prevalence of physical violence and the degrees to which respondents feel safe in their places of work, the five validated questions on perceptions of KSACPs, knowledge of and training status of PMDB-M, and a free response question on WPV.

The electronic survey was created using Survey Monkey in an online format accessible via web link and a QR code that could be scanned by a respondent's smartphone. Question formats varied, but included dichotomous responses, multiple choice, multiple selection, categorical, Likert scaling, and free response. Respondents were able to pause and return to their surveys at any point provided the survey was still open, and incomplete surveys could be submitted. Any respondent who indicated they had taken the survey before could not answer any subsequent questions but could submit the survey, only their response to the filtering question was recorded to allow for easy exclusion. It was estimated that the survey would take five minutes and ten seconds to complete, and the survey was piloted by 12 individuals prior to going live.

The authors' goal was to collect 50 completed surveys over one month's time to include in their analysis. The survey was distributed by both targeted and random effort. Web links were distributed by means of mass email distributions through both inpatient and outpatient executive leadership, with a focus on reaching HCWs in inpatient settings due to the risk demonstrated in this population. Distribution was expanded by the authors due to feedback received while conducting subjective interviews to include pharmacy, outpatient primary and specialty care clinics, occupational health, and outpatient behavioral health clinics. Additionally, the authors conducted several walk-abouts of the hospital footprint to engage additional staff with a focus on busy clinical areas based on the assumption many HCWs engaged in direct patient care would be less likely to routinely monitor email traffic.

Subjective interviews with key stakeholders. To inform all areas within the RE-AIM framework the authors planned to engage in multiple subjective interviews with key stakeholders throughout the organization. This not only included those staff members in leadership, but individual employees were considered a stakeholder in their own personal safety and that of their patients as well. Both structured and unstructured interviews were planned. Structured interviews were conducted with PMDB-M program manager and executive leadership. Unstructured interviews were conducted both at random during walk-abouts, and through planned interactions with staff in areas identified through either the literature or subjective report to be at a higher risk for violence. Structured interviews focused on the implementation and adoption of PMDB-M, policies in place regarding WPV, reporting methods and challenges, perceived prevalence and effects of WPV in their respective areas of responsibility, as appropriate. Unstructured interviews explored many of the same areas addressed in the electronic survey and would also rely heavily on the participants' ideas for challenges faced within and improvement for their respective places of work. Informal prevalence rates will be obtained from unit-level leadership to evaluate perceived need for training and threats of WPV from the leadership level.

Data Analysis Plan

Data analysis plans in the three arms: (a) mock code de-escalation simulations; (b) electronic surveys; (c) and subjective stakeholder interviews differed due to the varying information collected as well as the classification of that data. In all cases the primary focus remained the evaluation of PMDB-M's efficacy as a tool to increase the staff's perception of KSACP. The secondary focus area remains the exploration of the prevalence of violent events, trends in reporting and data collection, perceptions of and challenges to safety in the workplace, and identification of any potential barriers to safe execution of the healthcare mission. In all

cases the authors aimed to explore any relationships in outcomes to demographic descriptors including gender and ethnicity, as well as licensure, role in healthcare, and place of practice. The confidence interval for all analyses was set at 95% ($p=.05$) a priori.

Mock code data analysis plan. Grading, as determined by the developed key task checklist was evaluated after the grades of both evaluators were averaged. Scores were evaluated for differences between PMDB-M trained and untrained personnel, as well as by other demographic descriptors as mentioned prior. Pre and post perceptions of KSACPs were evaluated to determine if any differences exist between trained and untrained populations, or between genders, ethnicities, and other variables as mentioned before. After equal variance was proven or disproven, an independent t-test was utilized to explore differences in grading outcomes between populations. A paired t-test was then utilized to compare the pre and post perceived KSACP rating between groups. Descriptive analytics will be applied where possible, and where variance is noted, appropriate analysis will be conducted on a post hoc basis.

Electronic survey data analysis plan. The electronic survey was expected to generate a significant amount of data of which the authors analyzed and sought to present the most efficacious portions of this data, in respect to the scope of this program evaluation utilized in the scope of this program evaluation. Data that is not or cannot be analyzed by the authors by means of simple analytical testing is expected to undergo more complex analysis for use in follow-on study. The primary focus for data analysis from the electronic surveys was on the following: the perceived KSACPs of respondents; the perceived safety and rates of experienced and reported WPV; and reporting trends for WPV. In all cases the authors planned to assess for differences in outcome between gender, ethnicity, training status, and location whenever possible.

Data analysis of electronic surveys utilized an appropriate independent t-test after determining variance within the data set. An ANOVA was utilized to assess for differences in outcomes between place of work, role, and ethnicity. Descriptive analytics were compiled, and additional statistical analyses were conducted on a post hoc basis where variation in outcome was observed.

Subjective interviews with key stakeholder analysis plans. Comments and responses were recorded by the authors and reviewed at the conclusion of the program evaluation. Additionally, the authors planned on routine assessments throughout the data collection phase to ensure no need for immediate action had become apparent, as well as to further guide stakeholder interviews. The authors then analyzed the information collected to evaluate for trends in the information. It was planned for this qualitative data to inform trends and perspectives of HCWs in a manner that stakeholders can utilize.

Instrumentation

Krull and colleagues (Appendix D) 5-statement-survey was used with the author's permission. This short survey specifically measures "the perception of their knowledge, skills, abilities, confidence, and preparedness to manage aggressive or violent behavior" (Krull et al., 2019, p. 26). The authors of the survey report high reliability, with pre survey and post survey Cronbach's α as 0.9648 and 0.9737, respectively (Krull et al., 2019). This instrument lended itself to use in this project well, as it is both short in duration and of low complexity, both important as it was used serially in some instances. The aforementioned mock code key task checklist in conjunction with the scenario script was designed to grade learner performance against training objectives within PMDB-M. The electronic survey and its composition are discussed previously, as well as the design of the mock code de-escalation simulations.

Privacy Concerns

This project did not involve contact with patients actively receiving healthcare, nor did it involve access to protected patient health records; as such, there is no known danger of violating the Health Insurance Portability and Accountability Act (HIPAA). No protected health information (PHI) was collected during this project. The survey tools and mock codes utilized within this project's design did not collect any personally identifiable information (PII) of the staff members participating. The interviews aimed to aid the collection of qualitative information were collected without the notation of any identifying data in order to ensure the privacy of participants and encourage truthful and complete input from those with comments on the PMDB-M process or their perception of violence within their places of work. Pre-post survey packets and questionnaires were provided via PMDB-M training staff, stapled together into packets. Respondents were prompted to create a random four letter/number combination that does not consist of PII parcels (SSN, phone number, DOB) and write on their packets so they may be identified later should they participate in mock codes, and to assist in data analysis and comparison without using PII. The packets were kept under lock-and-key by the authors.

Lack of HIPAA concerns notwithstanding, a privacy review board was warranted and obtained. Additionally, the data collection plan involved data safekeeping best practices, including password encryption on government computers, and storage of physical property (surveys, mock code results, feedback) within suitably locked and secured areas.

Potential Barriers

The CV19 virus presented the greatest barrier to the timely completion of this program evaluation. Implementation of the PMDB-M curriculum had been halted prior to the author’s arrival due to concerns with infection control, on account of the close proximity required to teach

the program through its highest level. Though the authors attempted to remedy their inability to witness actual training events in person by using the programs records and the three arms of the project detailed above, not being able to directly observe training remains the greatest barrier. The military's force protection posture and increased operations tempo may also be expected to interfere with the program evaluation, as a large part of the project involved the assistance of other WAMC staff members who may have been engaged in other duties.

Results

This program evaluation was completed over the course of ten months with slight variations from the proposal. The most predominant variation was our inability to directly observe PMDB-M training in the facility due to CV19 precautions during this period of time. Despite this, all three proposed arms met their stated objectives, with statistically significant findings in each that proved likely to facilitate decision making by stakeholders and hospital leadership.

Mock Code De-escalation Simulation Results

A total of 22 mock code de-escalation simulations were implemented over the course of five days during the evaluation. Ten inpatient behavioral health and twelve inpatient medical or surgical staff members participated in the mock codes. Seven participants reported having been trained in PMDB-M previously, and 15 reported not having had the training at any time before. All of the participants who reported having received PMDB-M training were employed in inpatient behavioral health.

The KSACPs of all who participated in the mock code de-escalation simulations (N=22) was measured prior to and immediately following the simulation using the learner's perception survey tool (Krull et al., 2019), which examines a participant's perceived KSACP to perform a

stated task. When participants were asked to self-assess their ability to manage violent or aggressive behavior, a significant increase in scoring is noted between pre and posttest following analysis by a paired t-test. For knowledge, confidence, and preparedness there was an increase of 13% [t(21) = 2.21, two tail $p = 0.037$], 16% [t(21) = 2.80, two tail $p = 0.010$], and 15% [t(21) = 2.56, two tail $p = 0.017$], respectively. An increase in perceived skills by 11% [t(21) = 1.78, $p = 0.088$] and ability by 6% [t(21) = 2.01, $p = 0.056$] was not statistically significant (Table I1).

When the pre and posttest KSACPs of trained participants (n=7) were compared to those of the untrained participants (n=15) an increase in confidence [t(13) = 3.12, two tail $p = 0.008$] and preparedness [t(13) = 3.12, two tail $p = 0.008$] of 14% and 15% respectively was shown. No statistical difference was found in the reported increases in knowledge (12%, $p = 0.054$), ability (6%, $p = 0.172$), or confidence (7%, $p = 0.189$) in the trained vs untrained groups (Table I2).

The performance of those trained previously in PMDB-M vs those without training, as determined by the mean scores of two raters was evaluated using the key task checklist. The key task checklist consisted of interventions / behaviors demonstrated at mild, moderate, and severe levels of SP stress. The mild, moderate, and severe level interventions contained a maximum score of 8, 18, and 12 possible points, respectively. This accounted for a maximum overall total score of 38. A preliminary test for the equality of variances indicated that the variances in scores of the trained and untrained groups were not significantly different in the total (F =.407, $p = 0.139$), mild (F = .25, $p = 0.155$), moderate (F = .468, $p = 0.180$), or severe (F = 2.02, $p = 0.19$) levels of stress intervention performance. Therefore, a two-sample independent t-test was performed that assumed equal variances. Those who had been trained in PMDB-M performed better in all levels of stress interventions and in overall score, though the results were not statistically significant (Table I3).

Electronic Survey Results

242 respondents completed at least a portion of the survey. Seven responses were removed as the respondent indicated they had taken the survey previously, and another was removed as they did not answer this filter question. A further 32 surveys were removed as they failed to complete one or more of the five validated (Krull) responses embedded within the survey, the prevalence of violence, or the safety and reporting responses in the survey. Eleven responses were removed for incomplete demographic information. 191 surveys were included for analysis in this project. The average respondent spent four minutes and 34 seconds completing the survey, which boasted a 78% completion rate for all those who initiated. 226 surveys were submitted by means of the online web link, and 16 had submitted the survey by means of the scanned QR code during author walkabouts. The electronic survey surpassed its completed goal by 282%.

Respondents who reported having had PMDB-M training at any point in the past reported a statistically significant increase in all of the measured KSACPs, as opposed to respondents who reported not having had the training. After determining variance, the appropriate independent t-test was utilized to analyze for difference in the mean score between the trained and untrained group. Those who had PMDB-M training were observed to report greater perceived knowledge [15%, $t(36) = 2.37$, $p < .001$], skill [16%, $t(36) = 2.69$, $p < .001$], ability [11%, $t(29) = 3.54$, $p = 0.022$], confidence [16%, $t(34) = 3.54$ $p < .001$], and preparedness [14%, $t(19) = 1.97$, $p = 0.049$] as compared to those without training.

When compared to men (n=30) irrespective of reported PMDB-M training status, women (n=161) reported statistically significant lower perceived skill [-12%, $t(189) = -2.31$, $p = 0.021$], ability [-14%, $t(189) = -2.64$, $p = 0.008$], confidence [-14%, $t(189) = -2.44$, $p = 0.015$], and

preparedness [-14%, t(189) = -2.30, p = 0.022]. Perceived knowledge showed no variation from that reported in their male counterparts. It should be noted at this juncture that less than ten percent of women reported having taken PMDB-M, where nearly 15% of the men surveyed had.

No statistically significant difference in measured survey outcomes including KSACPs, perceived safety in the workplace, prevalence of WPV, and likelihood to report was observed for differences based on gender, ethnicity, shift worked, place of employment and role in healthcare. On average, night shift (n = 26) reported experiencing more incidents of WPV yearly (M = 2.11, SD = 4.02), as compared to those staff who primarily worked day shift (M = 1.57, SD = 3.90). Seventy-six respondents (66%) reported experiencing WPV sometime during their career. Of the 76 employees who reported ever experiencing WPV, 71 (93%) reported experiencing at least one incident of WPV in the preceding year. Those who reported experiencing WPV in the preceding year report a mean occurrence of 4.1 events in that same time.

The general perception of individual's safety in the workplace was measured using a Likert scale (0-100). African Americans (n = 47, M=79.5) reported the lowest perceived safety in the workplace, followed by Asian American and Pacific Islanders (n = 6, M = 79.8), Native Americans and Indigenous People (n = 5, M = 81.4), Hispanics and Latin Americans (n = 14, M = 83.5) and Whites or Caucasians (n = 108, M = 85.8). Further descriptive statistics are included in Appendix L. On average, men reported feeling safer (n = 29, M = 88.2) in the workplace than females (n = 160, M = 81.35).

Subjective Interviews with Key Stakeholder Results

The majority of staff members and leaders interviewed were enthusiastic about WPV prevention, and more often than not vocalized their support of and desire for more WPV training. Seven leaders of patient care areas responded to our requests to estimate the monthly occurrence

of verbal, or actual threatened or realized physical violence. Only one provided an estimate of monthly verbal violence of three occurrences, and the remaining six who responded were unable to commit to an estimate but acknowledged verbal WPV is more prevalent than tracked. Two leaders estimated two occurrences of physical violence monthly, with one of the leaders indicating a physical attack in the preceding 12 months that led to an injury of a staff member requiring missed time at work. The majority of individuals and leaders polled indicated that the threat of WPV is real, though opinions were mixed on the level of threat. Many nursing staff and licensed independent providers who shared their thoughts on WPV for the project conveyed a belief that risk from patients and family was inherent in their jobs. This sentiment was not echoed by administrative staff with whom we spoke.

Interviews with key leaders in several hospital departments were conducted to explore prevalence and reporting procedures for WPV. Although all departments fully cooperated with the study, none could present the authors with any reports of WPV. This stands in stark contrast with the electronic survey, which indicated the average respondent reported 0.6 incidents of violence in the preceding year, which extrapolates to 69 reported incidents of violence. What is not reported, however, is to whom or what entity the staff member reported those events. Interviews with key leaders indicated there were two separate and distinct reporting tools in use, one an enterprise-wide form and another a local form. Another form of recording WPV was reported to the authors of the study when a key leader reported the occurrence of an assault leading to the injury and lost time of a staff member, which was formally investigated by the command. The formal investigation report was not requested by the authors as it lay outside the IRB approval of the project. Hospital security acknowledged that incidents of WPV were

recorded, but no reports were provided, and it was not clear the exact department or individual responsible for this data collection.

Qualitative remarks were collected throughout the project, both within the survey and during subjective interviews. Over 50 encounters were documented, and direct quotes recorded in 33 instances. Remarks were independently categorized by both authors, and validated following discussion of any differences in categorization. These recorded remarks were analyzed and classified into primary concerns, nine of which were related to verbal violence, four over concern for physical violence, five over concern for both verbal and physical violence, three indicated concern over violence in the form of racism, two were unrelated to WPV, and ten could not be classified into the previous categories. Three respondents expressed specific concern with the unavailability of security to them in the hospital. Fifteen individuals remarked that they did not feel supported by leadership in reference to safety and safety reporting, and voiced frustration that reports they made had either been not followed up upon or had no effect.

Analysis of the Results

Efficacy of PMDB-M Training

PMDB-M training appears effective in increasing reported levels of perceived knowledge, skill, ability, confidence, and preparedness of staff members to prevent and respond to violent or disruptive behavior in the workplace. The effect of PMDB-M on these perceived outcomes is likely understated due to the fact it could not be taught on its prescribed annual basis due to CV19 restrictions, with the last documented instance of available training occurring over one year prior to data collection. It is reasonable to equate increased reporting of self-efficacy with increased performance managing violent or disruptive behavior due to a well-established

(Bandura, 1977) and often confirmed link in the literature (Talsma, Schuz, Schwarger, & Norris, 2018).

Utilization of Mock Code De-escalation Simulations

Participating in the mock code de-escalation scenarios, irrespective of PMDB-M training status, yielded increases in the reported knowledge, confidence, and preparedness of participants. Though minor increases in reported ability and skill observed were not statistically significant, they are likely still clinically relevant. Mock code simulations offer a safe environment for participants to practice skills resulting in improved performance (Hazwani et al., 2020). Further, mock code de-escalation simulations provide a medium to assess performance in a safe and controlled environment (Ironside et al., 2009). The literature boasts evidence that high fidelity simulations improve performance, especially in stressful situations such as those expected while managing violent or disruptive behavior (Bhullar, Alnaji, Clarke, & Lawrence, 2017; Morton, Powers, Jordan, & Hatley, 2019).

Gender, Ethnicity, and Violence

Although the statistical significance of observed disparities in perceived safety was not established, the decreased perceived safety of all ethnic groups, and Black Americans in particular, may hold clinical relevance and correlate with current social trends in the country. In general, Black and Asian Americans feel less safe in public as compared to their white counterparts (Ashburn-Nardo, Thomas, & Robinson, 2017; Gallup, 2020). Studies conducted by Ariel, Lembeck, Moffat, & Hertzog (2018) and Kahkoska, DeSelm, & Young (2020) found gender differences in comfort and preparedness when performing stressful tasks under pressure and scrutiny in favor of males compared to females. Our results would benefit from additional study but are likely indicative of trends seen in greater society at this time.

Workplace Violence and Reporting

A disparity between WPV incidents and reporting was observed, as expected and likely in line with the overall healthcare community. In healthcare settings, as low as 20% of violent events are being reported, and thus pose a great challenge in creating a safe environment and development and improvement in workplace violence prevention programs (Van Male, 2018). This program evaluation also identified a general lack of a standardized reporting process, central repository for this data, and staff understanding of the same in this institution.

Organizational Impact

This project was the first ever known program evaluation of the DoD's PMDB-M WPV prevention program at a military installation. It validated the efficacy of and supported the continued need for PMDB-M training in this military healthcare setting. The program evaluation also incorporated high-fidelity simulations in the program evaluation geared specifically towards PMDB-M for the first time, and derived sufficient data to drive recommendations to include similar simulations into initial and recurrent PMDB-M training.

This project also illuminated several areas for improvement, especially in reporting and tracking instances of WPV, and generated recommendations for the organization in order to further protect their patients, staff, and the ongoing mission of healthcare provision. Potential differences in perceived ability to handle WPV and overall feelings of safety were observed and allow the organization to take future measures to verify and correct any shortcomings to promote equity and reduce any possible gender or racial disparities.

The broad scope and scale of this program evaluation provided education to both staff and key leaders on the occurrence of and threat posed by WPV. As violence in the country continues to increase, rates of reporting among HCWs remain woefully inadequate, and the

authors view education as a crucial step in increasing this metric to protect safety. Lastly, this project educated staff in the need to include verbal aggression and violence in the spectrum of WPV while reinforcing the sentiment that their safety in the workplace as a HCW was important, and that violence must not be considered an engrained expectation of HCWs.

Future Directions for Research and Practice

Future research is required in multiple areas, and perhaps the first priority should be to conduct a similar program evaluation at another MTF to ensure similar results, as it is possible for distinct and different threats to safety and reporting to exist between varying organizations. Ideally, any follow-on program evaluation should occur outside of CV19 restrictions and witness the actual implementation of PMDB-M training to ensure fidelity with training guidance. Further evaluation of PMDB-M implementation becomes especially important in an enterprise as large as the MHS, as the potential exists for variations in PMDB-M training to effect outcomes in patient and staff safety. Specific attention should be paid in future studies to confirming any possible disparities in outcomes due to gender or ethnicity so solutions can be applied.

Specific to PMDB-M implementation and maintenance, the feasibility of expanding the brief and impromptu learning vignettes in PMDB-M to include scripted mock code de-escalation simulations similar to those in this project should be considered. Of particular interest, the observed increase in KSACPs of untrained staff who engaged in the simulations lead the authors to recommend further study in the use of simulation as recurrent training for staff. It is envisioned recurrent mock code de-escalation simulations, similar to mock code events found in Basic and Advanced Life Support training, for example, may increase staff and patient safety and should be further explored.

The importance of reporting events of WPV must not be understated. If WPV goes unreported there is no reason to believe efforts can be adequately targeted to effectively combat it. Although this program evaluation made no attempt to explain the relative absence of documented occurrences of WPV despite reported incidents of WPV, this is an area that should be considered in primary research moving forward. The authors also encourage leadership, at all levels, to continuously evaluate for and mitigate barriers to reporting WPV. Although primary research on WPV prevention programs has increased in the last several years, additional focus is warranted in this area to ensure delivery of evidence based and quality training programs.

Conclusion

Healthcare workers in the Military Healthcare System are not immune to the dangers of WPV, and prevention efforts remain critical in order to protect the healthcare mission and preserve readiness. PMDB-M training is an effective tool to educate hospital staff, both in and out of direct clinical care areas, on the recognition and management of disruptive or violent behavior. PMDB-M training also lays a foundation for learning basic customer service and de-escalation skills, which may benefit the organization in areas outside that of violence prevention. The expansion of PMDB-M training, at various levels, is likely to protect patient and staff safety, and the overall healthcare mission.

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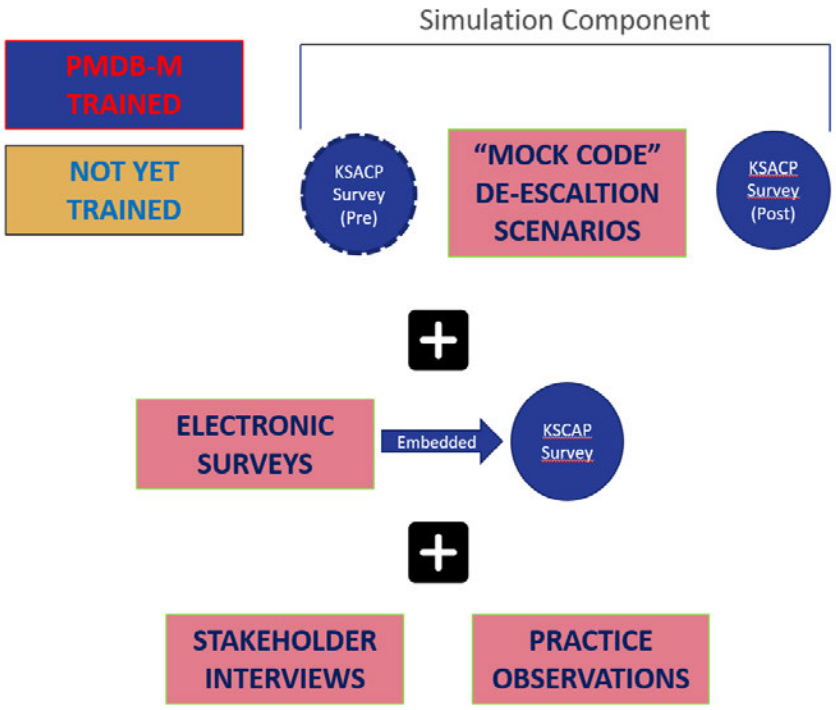
Appendix A

Project Design



Appendix B

WAMC IRB Letter of Determination

DEPARTMENT OF THE ARMY
WOMACK ARMY MEDICAL CENTER
2817 REILLY ROAD
FORT BRAGG, NORTH CAROLINA 28310-7324

MCXC-DQS September 02, 2020

MEMORANDUM FOR LTC Louis Michael Magyar, DNP LTC, AN Uniformed Services University of the Health Sciences (USUHS), P and R

SUBJECT: Determination for Project "Program Evaluation and Prevention of Management of Disruptive Behavior-Military (PMDB-M) at Fort Bragg's Womack Army Medical Center," 20-10942

1. The subject project was reviewed by the Womack Army Medical Center (WAMC) Human Research Protections Program (HRPP) Office for applicability of human subjects protections regulations.

2. The primary objective of the study is a program evaluation of PMDB-M guided by the RE-AIM framework to determine the program's efficacy and sustainability. Data collection will inform Reach, and Adoption. Efficacy will utilize mock code simulations, feedback, debriefing, and surveys. Implementation and Maintenance includes final recommendations based on analyzed data collected, lessons learned, and future sustainability. Evaluating the DoD WPV program PMDB-M will inform stakeholders of the program's effectiveness and sustainability. Evaluating the program will elucidate opportunities for improvement, with the overall goal of decreasing rate of WPV, improving patient outcomes, and simultaneously protecting the organization from additional financial expense.

3. This project does not constitute research as defined at 32 CFR 219.102(d) and DODI 3216.02 because this project is an Evidence Based Practice project that is providing program evaluation for behavioral health patient de-escalation and management training. The Prevention and Management of Disruptive Behavior-Military program will be evaluated under the EBP RE-AIM framework to determine if it is being effectively implemented for Womack Army Medical Center staff. This project has been reviewed by the Evidence Based Practice Council at Womack Army Medical Center and has been approved to proceed as an evidence based practice activity.

4. This project may be subject to approval from other departments at WAMC or outside agencies, but there is no further requirement for review by the WAMC HRPP Office.

5. In the event there is a change to the above-described project that may affect its determination, please submit a modification form in EIRB (https://dmrncac.dhhq.health.mil). The WAMC HRPP Office will re-evaluate the project if necessary.

MCXC-DME-RES
SUBJECT: Determination of Not Research for, Project "Program Evaluation of Prevention of Management of Disruptive Behavior-Military (PMDB-M) at Fort Bragg's Womack Army Medical Center," 20-10942

6. All publications, presentations or abstracts arising from this work must be cleared through appropriate publication clearance procedures, and should not refer to this project as research.

7. The point of contact for this review the undersigned at [redacted] or [redacted]

Jennifer S. Kuntz MLIS
EOD, Human Research
Protection Program

Appendix C

Key Task Checklist

Prevention and Management of Disruptive Behavior-Military (PMDB-M)

Stress Levels Normal to Severe Actions and Staff Actions

Date: _____

Participant #: _____

Unit: _____

Evaluator: Waters McLemore

Mild_____ **Mod** _____ **Sev** _____

Stress Level: Normal/Mild
Staff Action: Customer Service

- ☐ Allow the Person to Express Concern
- ☐ Use Shared Problem-solving Approach
- ☐ Demonstrate Empathy
- ☐ Be an Active Listener
- ☐ Avoid Being Defensive
- ☐ Apologize if Appropriate
- ☐ Follow Through with Their Problem
- ☐ Avoid Blaming Others or "Not My Job"

Stress Level: Moderate
Staff Action: Verbal Intervention

- ☐ Remain calm and in control
- ☐ Respect personal space
- ☐ Supportive body language
- ☐ Convey willingness to help
- ☐ Show Open Hands
- ☐ Non-threatening eye contact
- ☐ Present reality in a supportive fashion 15
- ☐ Identify the problem 16
- ☐ Focus on problem solving 17
- ☐ Give information 18
- ☐ Provide alternatives 19
- ☐ Summarize 20
- ☐ Create an action plan 21
- ☐ Validate the Person's Experience 22
- ☐ Ask Open Ended Questions 23
- ☐ Restate, Reflect, Clarify 24
- ☐ Suggest Collaboration 25

- ☐ Suggest Alternatives 26
  - ○ Schedule Appointment for Another Time
  - ○ Offering a Cold Beverage
  - ○ Relaxation / Visualization
  - ○ Distraction/Redirection
  - ○ Use of Quiet Room
  - ○ Change of Venue
  - ○ Walking, Mild Exercise
  - ○ Medication

Stress Level: Severe
Staff Action: Limit Setting

Limits:

- ☐ Simple and direct 27
- ☐ Using 5 words or less 28
- ☐ Describing the desired 29 behavior
- ☐ Giving options 30
- ☐ Appropriate to the situation 31
- ☐ Progressive in nature 32
- ☐ Must be enforceable 33

Actions:

- ☐ Clear and calm in your demeanor 34
- ☐ Non-threatening 35
- ☐ Encouraging 36
- ☐ Firm yet supportive 37
- ☐ Respectful and civil 38Non-threatening eye contact

Staff Action checklist adapted from T
PMDB-M Training Slides, October 2015. Retrieved from
https://info.health.mil/army/ahsd/PMDB/Documents/Forms/PMDBM.aspx

Appendix D

Learners' Perception Survey

Knowledge	SD	D	UD	A	SA
1. I have the knowledge needed to manage aggressive or violent patient behaviors.					
Skills					
2. I have the skills needed to manage aggressive or violent patient behaviors.					
Ability					
3. I have the ability manage aggressive or violent patient behaviors.					
Confidence					
4. I feel confident I can manage aggressive or violent patient behaviors.					
Preparedness					
5. I feel prepared to manage aggressive or violent patient behaviors.					

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

Appendix E

Mock Code Simulation Pre and Post Survey

Pre-simulation survey	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. I have the **knowledge** needed to manage aggressive or violent patient behaviors.					
2. I have the **skills** needed to manage aggressive or violent patient behaviors.					
3. I have the **ability** to manage aggressive or violent patient behaviors.					
4. I feel **confident** I can manage aggressive or violent patient behaviors.					
5. I feel **prepared** to manage aggressive or violent patient behaviors.					

1. **Are you Prevention and Management of Disruptive Behaviors Military (PMDB-M) trained?**

_____ Yes _____ No

2. **Do you work primarily in behavioral health? (inpatient or outpatient)**

_____ Yes _____ No

3. **How long ago was your last PMDB-M training?**

_____ Never _____Within 6 Months _____ 6months-1 Year _____1-2 Years _____ Over 2 Years

4. **How many times have you been trained?**

_____ Never _____1 times _____2 times _____3-4 times _____5 or more times

5. **How would you describe your occupational role?**

_____ Direct Patient Care _____Indirect Patient Care

_____ Supervisor _____ Administration

Participant # _____

6. How long have you been serving in your role (in above question)?

_____ 1 year _____ 2-3 years _____ 3-5 years _____ 5-10 years _____more than 10 years

7. What licensure or certification do you hold?

_____

8. What is your age in years?

_____ Under 18 _____ 18-24 _____ 25-34 _____ 35-45 _____ 45-54 _____ 65+

9. What is your ethnicity? (May select all that apply)

_____ White or Caucasian _____ Black or African American _____ Hispanic or Latino

_____ Asian or Asian American _____ American Indian or Alaska Native

_____ Native Hawaiian or Other Pacific Islander _____ Other (Please write in below)

10. What is your sex?

_____ Female _____ Male

PLEASE STOP HERE!!!

Post-simulation survey	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. I have the **knowledge** needed to manage aggressive or violent patient behaviors.					
2. I have the **skills** needed to manage aggressive or violent patient behaviors.					
3. I have the **ability** to manage aggressive or violent patient behaviors.					
4. I feel **confident** I can manage aggressive or violent patient behaviors.					
5. I feel **prepared** to manage aggressive or violent patient behaviors.					

Do you have any comments on workplace violence prevention / workplace violence within your unit or organization? (Write Below. Please do not list names or other identifying information.)

Appendix F

Inpatient Behavioral Health and Medical Surgical Unit SP and Participant Guidance

INPATIENT PSYCHIATRY SCRIPT

"Jack Bardgen"

Original case by Paul McLemore, RN and Geraldine Waters, RN
Adapted for use in PMDB-M Simulations

PRESENTING COMPLAINT: "I want to see my spouse, right now!"

ACTUAL DIAGNOSIS: Visitor

PATIENT DEMOGRAPHICS:

Age:	22
Sex:	Male
Race:	N/A

OBJECTIVES:

1. Seek to understand the problem and apply basic customer service skills.
2. Recognize and intervene should the individual become agitated.
3. Protect your patient's privileged information and the security of your unit.

EQUIPMENT NEEDED:

None

Participant Briefing:

You are the staff member covering the unit and are the most senior employee available. An employee you are training returns from the unit's locked front door requesting you to speak with a visitor outside who had asked them if it was possible to see their spouse. This is against hospital policy and you lack the authority to make exceptions to the rule. Although you are expected to address this situation without outside assistance, there is emergency help within shouting distance and a panic button you may activate by simply raising your arm.

Please help the customer to the best of your ability. The encounter will last no more than five minutes. In this scenario, the door to the inpatient unit is simulated by the door of the room you are about to enter. There exist no consents to release privileged patient information.

Participant #_____

INPATIENT PSYCHIATRY SCRIPT

Presenting Situation and Instructions to the Actor
"Jack Bardgen""

You are to play the dependent spouse of a patient on the locked inpatient unit. Your spouse may be either male or female at your discretion. You came home from working a long night shift to find he/she is missing. The patient had been depressed for some time, so at first you think the worst (suicide). You spent all morning calling hospitals, but no-one would speak to you. You received a phone call from your spouse roughly one hour ago, in which he/she informed you they were on 6S and were not being allowed to leave. Your spouse sounded scared, and you were too. They asked you to help them.

You are tired, nervous, angry, and scared all at once. You are relived to know they are safe, but anxious because you are being kept in the dark.

You want the following things, all of which the participant cannot provide:

1. The Story! What happened? Why? [Normal/Mild]

2. The release of your spouse! How can they hold him? [Moderate]

3. To see him right now! Visit on the unit [Moderate to Severe]

Guidance

1. Start slow and calm- ensure that you make your initial demand (The Story)

2. Escalate per established guidelines; asking for the release of your spouse should occur in the "moderate" level of stress.

3. Use suspicion that your spouse is in danger as a tool to "spin up"

Participant #_____

INPATIENT MEDICAL/SURGICAL UNIT SCRIPT

"Peter"

Original case by Paul McLemore, RN and Geraldine Waters, RN
Adapted for use in PMDB-M Simulations

PRESENTING COMPLAINT: "I want to see my spouse, right now!"
ACTUAL DIAGNOSIS: Visitor

PATIENT DEMOGRAPHICS:

Age:	22
Sex:	Male
Race:	SP

OBJECTIVES:

1. Seek to understand the problem and apply basic customer service skills.
2. Recognize and intervene should the individual become agitated.
3. Enforce the organization's policy to protect patients and staff

EQUIPMENT NEEDED:

None

Participant Briefing:

You are the staff member covering the unit and are the most senior employee available. A trainee requested for you to speak with a visitor outside asking if it was possible to see their spouse. Briefly, the patient's nurse tells you that he/she's been admitted overnight for observation. Labs are pending and the treatment team is yet to round on the patient.

Due to COVID-19, a no visitation policy is in place to protect patients and staff. You lack the authority to make exceptions to the rule. Although you are expected to address this situation without outside assistance, there is emergency help within shouting distance and a panic button you may activate by simply raising your arm.

Please help the customer to the best of your ability. The encounter will last no more than five minutes. In this scenario, the door to the inpatient unit is simulated by the door of the room you are about to enter.

Participant #_____

INPATIENT MEDICAL/SURGICAL UNIT SCRIPT

Presenting Situation and Instructions to the Actor
"Peter"

You are to play the spouse of a patient admitted to the medical/surgical inpatient unit for observation. Last night, he/she called 911 after experiencing sudden chest pain and shortness of breath. You were sent back from the field exercise to attend to your spouse. You received a phone call from your spouse roughly one hour ago, in which he/she is crying, asking you to be by his/her side. Your spouse sounded scared, and you were too.

You are tired, worried, and overwhelmed. Your spouse is in acute emotional distress and all he/she wants is for you to provide comfort and support.

You want the following things, all of which the participant cannot provide:

1. To know what exactly caused your spouse's chest pain, what the treatment team is going to do next, and to tell you that everything is going to be alright. [Normal/Mild]

2. To be allowed to visit your spouse! He/She wants you to be by her side! He/she is very anxious, crying uncontrollably, and just wants to be comforted! [Moderate]

3. Demand exemption to the policy! To be allowed in right now! [Moderate to Severe]

Guidance

1. Start slow and calm- ensure that you make your initial demand. You want medical information, the plan, and someone to say everything will be okay.

2. Escalate per established guidelines; you just want to comfort your spouse. Where is the compassion and empathy? "moderate" level of stress.

3. Challenge the "no exception" policy to spin up. You're wearing a mask, you don't have symptoms, you've been vaccinated, your spouse is in a private room. It doesn't make sense! They're allowing your spouse to suffer all on her own!

Participant #_____

Appendix G

Volunteer Briefing and Instructions

VOLUNTEER BRIEFING

Volunteer Briefing

Thank you for volunteering to participate in the de-escalation mock code scenarios. As a reminder, this activity is completely voluntary. If at any time you would like to withdraw, you may do so without any consequences whatsoever. This scenario, which will be briefed to you shortly, presents you with the opportunity to practice your customer service and de-escalation skills in a safe and controlled environment. The brief surveys we will ask you to complete will be kept confidential and will not include your names, they will help us evaluate the needs of the PMDB-M program. We will use a checklist to evaluate the application of key skills but remember, we are not grading you, we are evaluating the program. You can expect an observer to end the encounter abruptly, this is by design and in no way reflects your performance in the scenario. We will gladly provide some formative feedback following the exercise.

Rules and Guidelines

-At no time will the patient touch you.
-At no time should you touch the patient.
-You may discontinue at any time, simply raise your hand and leave the room.
-If the patient raises their hand, they have ceased the encounter, please leave the room.
- Evaluators may discontinue the scenario at any time, do not feel as if you have done anything wrong/incorrect.
-Personal space is an aspect of PMDB-M, but at no point will you be within 6-feet.

Trigger Warning

It is possible for simulated confrontations to be distressing to many individuals. Remember, you may discontinue at any time, simply raise your hand and leave the room. If you would like to speak with a health care professional about any feelings or thoughts that concern you, simply inform us. A handout containing contact numbers will be provided to you.

We are thankful for your willingness to help improve our organization, and hope you enjoy the opportunity to practice your skills in a safe environment!

This form was read in full and an emergency contact card was given to participant:

Paul McLemore: Geraldine Waters:

Participant #_____

Appendix H

Electronic Survey

Workplace Violence Survey

FORT BRAGG WORKPLACE VIOLENCE SURVEY AND PMDB-M PROGRAM EVALUATION

Thank you for taking a few moments of your time to provide your feedback on the threat of workplace violence (WPV) within your organization. This survey is part of a Uniformed Services University scholarly project and is not the result of any specific occurrences on the installation. This survey is *voluntary* and *anonymous*, no attempt will be made to identify you.

"Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors."-OSHA, 2020

1. Have you taken this survey before?
   - ◯ Yes
   - ◯ No

2. What is your gender?
   - ◯ Female
   - ◯ Male

3. What is your Ethnicity?
   - ☐ White or Caucasian Black or
   - ☐ African American Hispanic or
   - ☐ Latino
   - ☐ Asian or Asian American
   - ☐ American Indian or Alaska Native
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ Another race

4. What is your age in years?
   - ◯ Under 18
   - ◯ 18-24
   - ◯ 25-34
   - ◯ 35-44
   - ◯ 45-54
   - ◯ 55-64
   - ◯ 65+

5. Are you a: (please choose 1)
   - ◯ Civilian (Contractor)
   - ◯ Active Duty Enlisted (E-1 to E-5)
   - ◯ Active Duty Enlisted (E-6 to E-9)
   - ◯ Civilian (GS)
   - ◯ Active Duty Officer (O-1 to O-3)
   - ◯ Active Duty Officer (O-4 to O-6)

6. What best describes your contact with patients in your current position:
   - ◯ Direct Patient Care and Interaction (Clinical Care / Administrative Support)
   - ◯ Management/Leadership
   - ◯ Little or Infrequent Direct Care and Interaction with Patients
   - ◯ No direct patient care or interaction

7. Which selection best describes your current role:
   - ◯ Registered Nurse (RN)
   - ◯ Physician (MD/DO)
   - ◯ Nurse Practitioner (NP)
   - ◯ Physician Assistant (PA)
   - ◯ Licensed Practical Nurse (LPN/LVN)
   - ◯ EMT/MEDIC
   - ◯ Patient Care Technician (Non-Psychiatric)
   - ◯ Psychiatric Patient Care Technician
   - ◯ Medical Support Assistant (MSA)
   - ◯ Student
   - ◯ **Other** (please specify)
   - ◯ Volunteer (Red Cross or Other)
   - ◯ Environmental Services
   - ◯ Security/Law Enforcement
   - ◯ Pharmacist
   - ◯ Pharmacy Technician
   - ◯ Social Worker (LICSW)
   - ◯ Psychologist
   - ◯ Administrator
   - ◯ Patient Advocate / Resolutions

8. How many years have you worked in your current role?
   - ◯ Less than 1 year
   - ◯ At least 1 year but less than 3 years
   - ◯ At least 3 years but less than 5 years
   - ◯ At least 5 years but less than 10 years
   - ◯ 10 years or more

9. Which option best describes where you primarily work:
   - ◯ Inpatient (Medical/Surgical)
   - ◯ Inpatient (Critical Care)
   - ◯ Inpatient Behavioral Health
   - ◯ Outpatient Clinic (Primary Care / Internal Medicine)
   - ◯ Outpatient Clinic (Surgery)
   - ◯ Emergency Department
   - ◯ Outpatient Behavioral Health
   - ◯ Non-Patient Care Area / Office Setting
   - ◯ **Other** (please specify)
   - ◯ Radiology
   - ◯ Pharmacy
   - ◯ Occupational Health
   - ◯ Administrative / Non-Patient Care Area
   - ◯ Operating Room
   - ◯ Perioperative Care (SDS/PACU)
   - ◯ Maternal Child Care (MBU/L&D/NICU)
   - ◯ Outpatient Clinic (Pediatrics)

10. How many years have you worked in this setting?

11. The **majority** of your scheduled shifts are:

- During normal business hours (Mon-Fri / Daytime)
- Outside of normal business hours (Eve/Nights and/or Weekends)

12. Have you **ever** personally witnessed or experienced workplace violence (either verbal or physical)?

- Yes
- No

13. How many workplace violence occurrences have you witnessed or experienced in the **past year**? (Best Estimate, 0 if None)

14. How likely are you to report an incident of **PHYSICAL** violence?

0 Not Likely to Report 10 Very Likely to report

15. How likely are you to report an incident of **VERBAL** aggression/violence?

0 Not Likely to Report 10 Very Likely to report

16. How likely are you to report an incident of **THREATENED VIOLENCE** in your workplace?

0 Not Likely to Report 10 Very Likely to report

17. If you were to report an incident of workplace violence, how would you go about reporting an episode of physical or verbal violence? (Select all that may apply)

- Supervisor
- Patient Safety Report (PSR)
- Patient Safety Office
- Staff Safety Office
- Patient Advocate
- Police/Provost Marshall
- Hospital Security
- I would not report the event
- Unsure of how or who to report to
- **Other** (please specify)

18. Have you **ever** *personally* reported an incident of physical or verbal violence?

- Yes
- No

19. How many incidents of workplace violence have you reported in the **past year**?

20. On an average day, how safe do you feel in the workplace?

0 Not Safe 100 Very Safe

21. I receive adequate training to keep me safe in the workplace

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

22. My safety in the workplace is a priority to the organization

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

23. My organization believes that my personal safety is **more** important than customer service.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

24. I have heard of Prevention and Management of Disruptive Behavior-Military (PMDB-M) before.

- Yes
- No

25. I have taken PMDB-M training before

- Yes
- No
- Unsure

26. I last took PMDB-M training:

- NA (I have never taken PMDB-M)
- Unsure
- Within 6 months
- 6 months - 1 year
- 1-2 years
- Over 2 years ago

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

- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree

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

- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree

29. I have the **ability** manage aggressive or violent patient behaviors.

- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree

30. I feel **confident** that I can manage aggressive or violent patient behaviors.

- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree

31. I feel **prepared** to manage aggressive or violent patient behaviors.

- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree

32. Would you like to provide any anonymous comments on workplace violence within your organization?

- No
- Yes (please specify)

Appendix I

Table I1. Mock Code Pre and Post Survey Scores

Mock Code	Pre	Post	% Increase	P-value
Knowledge	3.41	3.86	13	0.037
Skills	3.36	3.72	11	0.088
Ability	3.63	3.86	6	0.056
Confidence	3.32	3.86	16	0.010
Preparedness	3.27	3.77	15	0.017

Table I2. Mock Code

Mock Code Pre and Post Surveys Trained vs Untrained	% Increase	P-value
Knowledge	12	0.054
Skills	5	0.335
Ability	7	0.189
Confidence	14	0.008
Preparedness	15	0.008

Table I3. Mock Code Performance

Mode Code Key Task Checklist	Mild	Mod	Severe	Total
Trained (n=9)	5.79	12.86	8.14	26.8
Untrained (n=12)	5.35	11.57	6.71	23.62

Appendix J

Perceived Safety in the Workplace by Ethnicity

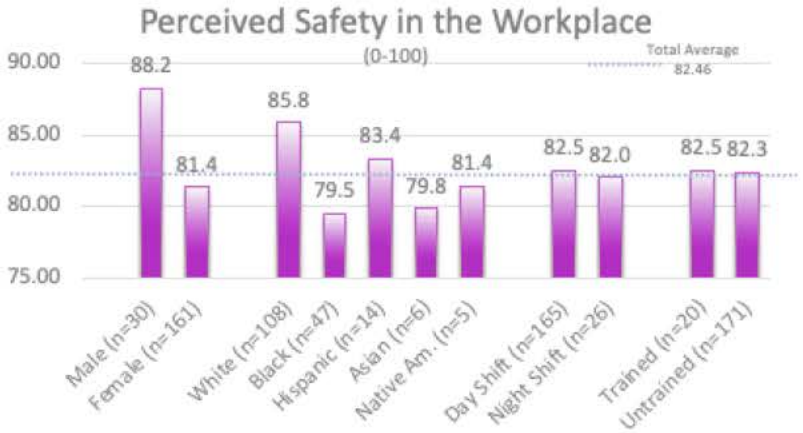


Table J2

Category (n)	% Experienced WPV (Lifetime)	% Reported WPV (Lifetime)	WPV Experienced in Past Year	WPV Reported in Past Year
Total (N=191)	66%	58%	μ 1.63 (SD= 0.49)	μ 0.60 (SD= 1.97)
Male (n=30)	67%	42%	μ 1.73 (SD= 0.46)	μ 0.26 (SD= 0.63)
Female (n=30)	66%	51%	μ 1.63 (SD= 0.48)	μ 0.65 (SD= 2.12)
Day Shift (165)	---	---	μ 1.57 (SD= 3.90)	μ 0.51 (SD= 1.45)
Night Shift (26)	---	---	μ 2.11 (SD= 4.02)	μ = 1.07 (SD= 4.02)

Table J3

Category (n)	Perceived Safety (0-100) μ	Likelihood to Report WPV (0-100) μ	WPV Experienced in Past Year	WPV Reported in Past Year
Nursing (n= 82)	83.1	80.3	μ 1.70 (SD= 3.25)	μ 0.73 (SD= 2.51)
Pt Care Tech/Medic (n= 8)	88.1	94.7	μ 0.5 (SD= 1.06)	0.0
Licensed Independent Providers (n= 26)	88.6	84.5	μ 0.61 (SD= 1.09)	μ 0.11 (SD= 3.02)
Administrator (n= 11)	82.7	91.5	μ 2.81 (SD= 5.98)	μ 1.36 (SD= 3.58)
Medical Support Assistants (n= 10)	72.4	94.3	μ 0.6 (SD= 1.26)	μ 0.2 (SD= 0.42)
Pharmacy (n= 54)	79.4	91.0	μ 2.18 (SD= 5.43)	μ 0.61 (SD= 1.20)

Appendix K

CITI Certificates

Completion Date 26-Aug-2018
Expiration Date 25-Aug-2021
Record ID 28226169

This is to certify that:

Geraldine Waters

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR) (Curriculum Group)
Responsible Conduct of Research (RCR) (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w22e46ac3-c965-4fba-8c72-99db9d1acdc9-28226169

Completion Date 29-Aug-2018
Expiration Date 28-Aug-2021
Record ID 28368564

This is to certify that:

PAUL McLEMORE

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR) (Curriculum Group)
Responsible Conduct of Research (RCR) (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?we12b5537-f1a7-4724-9574-dbfdc5c87f02-28368564

CITI PROGRAM

Completion Date 25-Aug-2018
Expiration Date 24-Aug-2021
Record ID 28226168

This is to certify that:

Geraldine Waters

Has completed the following CITI Program course:

Good Clinical Practice (U.S. FDA Focus) (Curriculum Group)
GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus) (Course Learner Group)
1 - GCP (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wf6ffe94b-92b5-47bb-b1a5-bd32644b8308-28226168

CITI PROGRAM

Completion Date 29-Aug-2018
Expiration Date 28-Aug-2021
Record ID 28368563

This is to certify that:

PAUL McLEMORE

Has completed the following CITI Program course:

Good Clinical Practice (U.S. FDA Focus) (Curriculum Group)
GCP for Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus) (Course Learner Group)
1 - GCP (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w045ccebe-5f90-4721-8f45-ed3dcb55b12c-28368563

CITI PROGRAM

Completion Date 25-Aug-2018
Expiration Date 24-Aug-2021
Record ID 28226167

This is to certify that:

Geraldine Waters

Has completed the following CITI Program course:

OUSD P&R Human Research (Curriculum Group)
Biomedical Investigators and Research Study Team (Course Learner Group)
1 - Biomedical Investigators (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w9e736c6d-4fe4-49ee-b8dd-4ca0a6291d1b-28226167

CITI PROGRAM

Completion Date 29-Aug-2018
Expiration Date 28-Aug-2021
Record ID 28368562

This is to certify that:

PAUL McLEMORE

Has completed the following CITI Program course:

OUSD P&R Human Research (Curriculum Group)
Biomedical Investigators and Research Study Team (Course Learner Group)
1 - Biomedical Investigators (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w8090e359-04b9-4def-a597-fef7d3e6c9e1-28368562

Appendix L

USU (VPR) Form 3202N

USU
Uniformed Services University

OFFICE OF RESEARCH
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814
PHONE: (301) 295-3303; FAX (301) 295-6771

NOTICE OF PROJECT APPROVAL

Change Number: Original

VPR Site Number:	GSN-61-11540
Principal Investigator:	McLemore, Paul
Department:	Graduate School of Nursing
Project Type:	Student
Project Title:	Prevention and Management of Disruptive Behaviors-Military (PMDB-M) Program Evaluation at
Project Period:	9/25/2020 to 2/15/2021

Assurance and Progress Report Information:

Name	Sup	Approval Type	Status	Approved On	Forms Received
Progress Report	0			To be Submitted	N/A

Remarks:
This Notice Of Project Approval has been reviewed and approved. Please remember that you must submit a final Progress Report (Form 3210) upon completion of this project.

Questions regarding this approval should be directed to the following person in the Office of Research:
Sharon McIver, (301) 295-9814.

[redacted]

Toya V. Randolph, Ph.D., MSPH Date
Acting Vice President for Research
Uniformed Services University of the Health Sciences

cc: File
Kenneth Radford
Laura, Taylor

Appendix M

Womack AMC Public Affairs Office Clearance

DEPARTMENT OF THE ARMY
WOMACK ARMY MEDICAL CENTER
2817 REILLY ROAD
FORT BRAGG NC 28310-7301

MCXC-ME-RCI 7 April 2021

MEMORANDUM FOR Louis Magyar

SUBJECT: WAMCPC0816 Program Evaluation of Prevention and Management of Disruptive Behaviors (PMDB-M) - Military at Fort Bragg's Womack

1. Your publication has been reviewed by all appropriate personnel and approved by the Department of Research for public presentation/submission.

2. This approval allows you to present the approved publication at other venues so long as only minor changes have occurred.

3. Thank you for your submission, and we look forward to seeing your scholarly activity in the near future. Please include the title of your publication and reference number in all correspondence.

4. The POC for this memorandum is Christy Crawford at [redacted]

Christy Crawford
Research/Clinical Investigation
Womack Army Medical Center

Appendix N

Uniformed Services University PAO Approval