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Protecting Healthcare Workers From Violence

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This doctoral project, directed and approved by the candidate's committee, has been accepted by the College of Graduate and Professional Studies of Abilene Christian University in partial fulfillment of the requirements for the degree.

Doctor of Nursing Practice

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Protecting Healthcare Workers From Violence

A doctoral project submitted in partial satisfaction

of the requirements for the degree of

Doctor of Nursing Practice

by

Terry L. Taylor

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Dedication

To my husband William E. Taylor II, MD. To my two sons Daniel and Loren Baker and their technology skills. To my four grandchildren, Benjamin, Avery, Korben, and Lyla Baker.

Acknowledgments

I would like to thank my chairperson, Dr. Gibson, for her openness in sharing her personal experiences while completing her DNP. Her encouragement gave me the courage to believe the DNP could be accomplished. I also want to thank my committee members, Dr. Atobajeum, Dr. Matero, and Dr. Lumpe, in assisting with this milestone. Thank you to my advisor Hope Stanphill and Chelsea Johnson for editing recommendations.

Abstract

Growing violence in the community increases the risks of injuries to healthcare workers. This project assessed the levels of emotional exhaustion, depersonalization, and acknowledgment of professional accomplishments in healthcare workers in the community who were responsible for the care of confused and combative clients. The community healthcare workers were assessed using the Maslach Burnout Inventory-Human Services Survey-Medical Personnel. An intervention was then presented, which focused on self-awareness, including mood assessments, soothing rhythmic breathing, compassionate focused imagery, and the creation of a safe place to process criticism compassionately. The participants were resurveyed after 30 days by repeating the Maslach Burnout Inventory-Human Service Survey-Medical Personnel. The project used a quantitative research method that assessed descriptive statistics with the comparison of means and standard deviations. The inference statistics were determined by the paired sample *t* test. The project concluded that the intervention significantly improved emotional exhaustion with slight improvements for depersonalization and professional accomplishments.

Keywords: emotional exhaustion, depersonalization, professional accomplishments, self-awareness, rhythmic breathing, and compassionate imagining

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Chapter 1: Introduction

Daily news stations report current crimes and violence from neighborhoods across America and around the world. Children play video games filled with gunfire and killing. American citizens watched with shock as 17 high school students were shot and killed in February 2018 at a Florida school. The shooter was a young man who believed this act of violence was necessary to prove his struggles (Lupoli, 2018). In Maryland, five people died during a newsroom shooting committed by an angry man whose prior crimes had been publicized (Stevens & Victor, 2018). In 2015, shootings in U.S. hospitals increased by 46% (Rege, 2017).

Disturbing and unimaginable acts of violence occur within public and private hospitals intended for healing, comfort, support, and recovery. Violent individuals from the community victimize healthcare workers who are dedicated, educated, and experienced in providing services for individuals. These incidents create conflict for the healthcare workers willing to care for the ill but not expecting to be injured physically or psychologically. Studies are being conducted to understand better how to increase safety for communities, patients, and healthcare workers.

Statement of the Problem

Confused, combative clients cause casualties. Contributing to the casualties is the cost: the emotional cost (Mansour Al-Ali et al., 2015) with a negative impact on morale (Hill et al., 2015), and the cost of burnout causing poor job satisfaction and attrition from staff turnover (Hill et al., 2015). Exposure to violence can decrease psychological well-being and cause depression, anxiety, and depersonalization (Ruiz-Hernández et al., 2016). Nurses and healthcare workers caring for violent patients can become desensitized (Johnson, 2014) by normalizing degrees of violence.

According to the American Hospital Association, the fiscal cost to manage violence by hospitals and health systems was estimated at $2.7 billion in 2016. Facilities spent $1.1 billion on security with violence prevention training; $852 million was spent on care for staff injuries, including $429 million on the staff's medical care, with the balance spent replacing the lost workforce. Plus, another $280 million was spent on preparedness and prevention (Hummel & Blanchard-Saiger, 2017).

Background of Problem

According to the Occupational Safety and Health Administration (OSHA), in 2015, violent patients caused 80% of injuries to nurses and healthcare professionals. Other clients caused twelve percent of injuries to nurses and healthcare professionals or customers like family and relatives (OSHA, 2015.). Mental health workers and emergency room staff have the greatest exposure to violent patients resulting in the highest incidence of injuries (Abou-ElWafa et al., 2015). Adding to the problem, healthcare workers who are in hospital patient rooms with violent patients alone and nurses with less than four years of experience are at a higher risk for a violent incident (Adams, 2017).

Purpose of Project

The purpose of this Doctor of Nursing Practice (DNP) project was to reduce nurses' and healthcare workers' physiological and psychological injuries caused by violent patients and to promote self-recovery or self-soothing following the healthcare worker's involvement in a violent incident. Evidence provided by Kivivuori (2014) suggested cultural sensitivities to violence increases when society has higher levels of exposure to violence. As a result, little infractions of violence become viewed as normal. Sensitivities can alter the perceptions of violence, and when a person has been victimized, they are less likely to view conflict as violent

(Kivivuori, 2014). Nurses and healthcare workers with greater exposure to violence in the psychiatric wards and the emergency room may have different perspectives on patient conflict. The purpose of this DNP project is to determine if healthcare workers are changed by frequent exposure to violent patients and to establish strategies for the maintenance of healthcare workers' and patients' safety.

Evidence collected from allied professionals coping with violence in a study showed elevated levels of cortisol. Cortisol is a glucocorticoid steroid hormone known as the stress hormone deregulator. Cortisol is the product of cholesterol in the adrenal glands, which prepares the body for fight or flight by flooding the large muscles with glucose for immediate energy. According to studies, normal cortisol levels tend to be higher early in the day and lower later in the day. However, when a person is under stress, cortisol levels, which are normally high in the morning, remain high longer throughout the day (Galovski et al., 2016). These higher levels of cortisol can affect the arterial elasticity, narrowing the arteries, and forcing the heart to pump faster. Elevated cortisol levels increase appetite, which can lead to weight gain, indigestion, and irritable bowel syndrome. Additionally, elevated cortisol levels can also suppress the immune system.

Galovski et al.'s (2016) study found that women have higher stress levels than males related to additional responsibilities in the home. Women's higher levels of stress increase the risk of suicidal ideation. Galovski et al. also reported that staff working during daytime hours have issues with depression and suicide. Additionally, healthcare workers scheduled during the evening and night shifts have more issues with post-traumatic stress syndrome (PTSD) and depression. Also, evidence indicates healthcare workers underreport violent events and become desensitized to frequent exposure to violence. The belief that there should not be an emotional or

physical reaction to a violent patient perpetuates the stigma that the risk comes with the job. This stigma can cause healthcare workers to fail to recognize and report injuries. Emotionally, healthcare workers are convinced that an injury would be proof of their unsuccessful job performance. Healthcare workers are concerned that reporting injuries take time with possible changes in their work schedule, affecting their salary. The problem in failing to report an injury, according to Galovski et al. 's findings, is that workers create a delay in treatment and risk worsening physical and psychological symptoms, which increases costs for hospitals and community care programs. Healthcare leaders need to encourage healthcare workers to report injuries without delay.

Significance of the Problem

The significance of this DNP project was that healthcare workers were injured when caring for violent patients. Millions of dollars are spent annually as healthcare workers are injured. Also, it is important that hospitals and community programs are compliant with OSHA policy, the Bureau of Labor regulations, and state laws. Leaders who appropriately recognize the value of their employees show respect by utilizing OSHA's theme "zero tolerance for violence."

Nature of the Project

The nature of this DNP project was an evidenced-based quantitative study with goals to reduce healthcare workers' trauma by encouraging self-recovery and allowing for the continuation of safe patient care. Prior studies and interventions have not been promising in eliminating violence in hospitals (Adams, 2017). This DNP project acknowledges that violence in the community and hospitals is a daily risk for healthcare workers. The plan was to identify symptoms manifested in healthcare workers who have been exposed to violence to discover if there are issues of job dissatisfaction, depersonalization, and fatigue with emotional exhaustion.

Then, an intervention was presented to the healthcare workers with a focus on self-recovery and stabilization.

Evidence shows that healthcare workers satisfied with their job will remain on staff longer and grow to be an experienced and valuable asset to the team. Healthcare workers who are personalized are connected with patients and will provide their patients with more autonomy (Owens, 2015). Emotional stability increases the energy levels that drive healthcare workers to be efficient with medications, assessments, documentation, and relationships. Therefore, leadership invested in quality patient care will cultivate these characteristics in healthcare workers by determining what erodes job satisfaction, personalization, and emotional stability.

Research Questions

RQ1: Will community healthcare workers who care for confused and combative clients have emotional exhaustion, depersonalization, and a poor sense of professional accomplishment?

RQ2: Will community healthcare workers with emotional exhaustion, depersonalization, and a poor sense of professional accomplishments benefit from an intervention focused on self-care?

The PICOT Research Question

- Population: Community healthcare workers caring for confused and combative clients.
- Intervention: To provide resources through a therapeutic intervention PowerPoint that includes a violence diary identifying behavioral reactions during a violent occurrence, I-mood apps, and techniques for self-recovery and self-soothing. To encourage debriefing that would promote healthcare workers' self-recovery and self-soothing following a violent episode.

- Comparison: The healthcare workers will pretest with a survey, then participate in a therapeutic intervention. Four weeks following the therapeutic intervention, the healthcare workers will repeat the survey. A comparison of the pretest and posttest scores will be evaluated for changes. Will the project show that healthcare workers caring for violent patients have more job satisfaction and better personalization with more emotional energy after a therapeutic intervention?
- Outcome: A therapeutic intervention on self-recovery and self-soothing will improve the healthcare worker's job satisfaction, personalization, and emotional energy.
- Time: One week prior to the intervention, there will be a campaign to invite participants to attend a lunch and learn project. Four weeks following the lunch and learn intervention, community healthcare workers will be contacted to repeat the Maslach Burnout Inventory Hospital Service Survey for Medical Personnel (MBI-HSS-MP).

Hypothesis

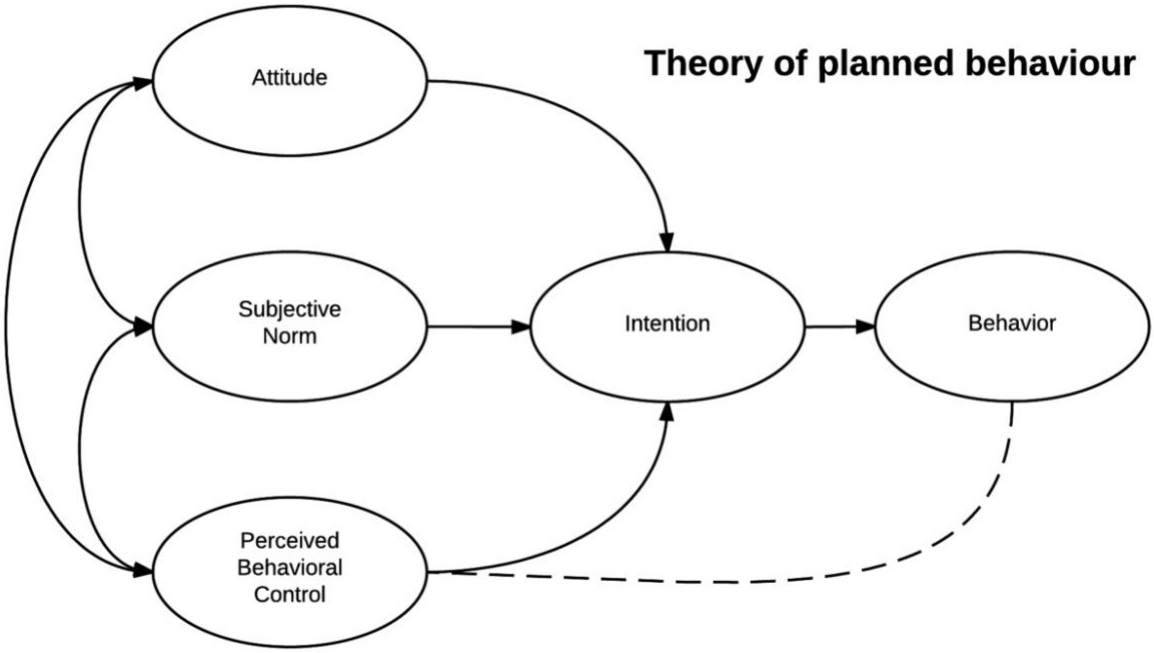
The hypothesis was that healthcare workers caring for confused and combative clients would have a higher risk for job dissatisfaction, depersonalization, and emotional exhaustion. The null hypothesis (H0) is as follows: Community healthcare workers who care for confused and combative clients will have average ratings for job satisfaction, depersonalization, and emotional exhaustion. The alternative hypothesis (H1) is as follows: Community healthcare workers who struggle to care for confused and combative clients would benefit from more resources and support.

Conceptual Framework

The project's conceptual framework used a behavioral approach in conflict resolution combined with the theory of planned behavior (see Figure 1). Ajzen (2011) theorized planned behavior as a way to "improve the predictive power of reasoned action by including perceived behavior control" (p. 1115). Simply stated, the attitude, subjective norm, and perceived behavior control can predict the intention of the behavior. For example, if a patient presents as agitated because of a positive drug screen but the healthcare worker perceives the patient's agitation as expected or normal, this could cause the nurse to underreact, causing a delay in care. If the healthcare worker is emotionally exhausted, this could slow the behavior to react and provide care. Should the healthcare worker be less personal, less sensitive, or less connected to the patient's agitation, this could result in the healthcare worker overreacting, which could also worsen the patient's agitation. Is the healthcare worker afraid and then freezes, thus unable to respond to the red flags of danger? Ajzen's (2011) theory of planned behavior could be applied in assessing a patient's behavior and healthcare workers' reactions. With this assessment, recommendations then could suggest improvements in the healthcare worker's plans for better safety measures when caring for violent patients. Programs could also be developed to assist healthcare workers in methods for self-recovery or self-soothing following a violent event.

Figure 1

Theory of Planned Behavior



Note. Adapted from "The Theory of Planned Behavior Diagram," by I. Ajzen, 2019, University of Massachusetts Amherst (https://people.umass.edu/aizen/tpb.background.html). Copyright 2019 by Icek Ajzen. Reprinted with permission to copy and use this figure free of charge in a dissertation.

Definition of Key Terms

Depersonalization. Depersonalization involves reflecting indifference and distant attitudes toward work (Ruiz-Hernández et al., 2016).

Emotional exhaustion. The loss of emotional resources because of work can be defined as emotional exhaustion (Ruiz-Hernández et al., 2016).

Fatigue. Feelings of tiredness, weakness, and bodily discomfort are characteristics of fatigue (Ruiz-Hernández et al., 2016).

High-risk violent patient. A high-risk violent patient may be responsible for physical assault, causing injuries, shouting, verbal threats, inappropriate sexual behavior, sexual assaults, use of a weapon, damage to property, setting fires, harm to animals, and self-injurious behavior (Harris et al., 2010).

Low-risk violent patient. A low-risk violent patient exhibits lower levels of agitation, no threats, is not sexually inappropriate, does not damage property, and is not a danger to themselves (Harris et al., 2010).

Nonphysical violence. Hurtful verbal threats, insults, and shouting are considered forms of nonphysical violence (Spector et al., 2015).

Physical violence. Intentional contact with staff to cause injury is considered physical violence (Spector et al., 2015).

Workplace violence. When a worker suffers injury, threats, or aggression, which affects their safety or well-being, they have experienced workplace violence (WPV; Ruiz-Hernández et al., 2016).

Scope of the Project

The scope of this DNP project was to examine literature that identifies types of emotional and mental injuries to healthcare workers exposed to violent patients. Healthcare workers exposed to violence were surveyed to determine if there was evidence of changes in their behavior. This DNP project also examined self-awareness methods to build resilience with improved job satisfaction, better personalization, and less emotional exhaustion. The DNP project could make recommendations in methods to reduce costs caused by required medical treatment for healthcare workers' injuries that lead to the loss of workforce hours. Also, a better understanding of healthcare workers' reactions and recovery from trauma caused by exposure to

violence could assist with the development of a plan to improve compliance with OSHA and state laws.

Chapter Summary

Hospitals and communities are experiencing higher levels of violence, creating conflicts for healthcare workers who want to be successful caring for those who are ill. This exposure to violence can have a lingering negative effect on individuals physiologically and psychologically (Feitosa Sousa et al., 2018). Frequently, healthcare workers' physiological and psychological reactions are not acknowledged, causing delays in recovery, which can interfere with a healthcare worker's personal safety. This trauma can cause distress that can create distractions, thus decreasing the healthcare worker's concentration needed to avoid errors. This project's goal was to promote healthcare workers' recovery following trauma by enabling them to continue caring for unpredictable, confused, and combative clients.

Chapter 2: Literature Review

This evidence-based quantitative DNP project was based on a literature review focused on the findings of community healthcare workers' emotional and mental reactions during the care of confused and combative patients. Keywords used for the literature search included violent patients, high risk, job dissatisfaction, depersonalization, and emotional exhaustion. In 2017, there were over 77,140 published scientific articles on the topic of violence. The search was narrowed by eliminating articles based on the topic found in the title. Topics eliminated included violence management in places of containment for criminal behavior, violence management in primary and secondary school, violence management on college campuses, the management of violence in the community, domestic violence, and horizontal violence or staff-on-staff violence including bullying in hospitals. Topics were narrowed to confused and combative clients in a community healthcare setting.

The search engines used were CINAHL, PsycINFO, and PsycARTICLES. The literature reviewed included qualitative, quantitative, and case studies in nature. The articles chosen for this project focused on healthcare workers' emotional, mental, and behavioral reactions to violence.

Theoretical Framework Discussion

The theory of planned behavior developed by Ajzen (2011) described a phenomenon with intentional behavior and consequential outcomes. For example, walking into a bar will result in having a drink. Working with a confused and combative client will have expected outcomes related to exposure to violence. The literature review focuses on identifying types of violent behavior that could cause a traumatic reaction for healthcare workers.

The DNP project's conceptual framework was based on behavior and emotional adaptation because violence in healthcare is both physical and psychological. However, there is more psychological violence than physical violence. In an eight-hour period, there are 2.29 psychologically violent events compared to 1.18 physically violent events (Dal Pai et al., 2018). Healthcare workers exposed to these levels of violence will be at risk for higher job dissatisfaction, higher depersonalization, and higher emotional exhaustion. Mandatory assaultive training, back-up security, and positive support from leaders for emergency room and mental healthcare workers would be beneficial resources (McKeown et al., 2016).

Literature Review

Behavior of Patients

Illnesses requiring hospitalizations and community support may push individuals into a confused and combative state. Not surprisingly, ill clients have the potential to become angry, aggressive, and hostile (Marshall et al., 2017) when out of their normal routine and environment. Altered mental status behaviors identified in clients could include confusion, psychosis from substances, delirium, psychiatric disorders, and dementia with personality disorders. Clients who are assessed with these symptoms should be monitored for violence. Maladaptive patient behavior like physical and psychological violence (Marshall et al., 2017) can cause an increase in verbal aggression, especially when issues from outside the hospital occur. Zhou et al. (2017) concluded in a study that there was an increase in psychological and physical aggression when healthcare workers attempted to administer medications to the client, request the completion of activities of daily living (ADLs), or limit sitting, especially with regards to no smoking.

Ridenour et al. (2015) made a distinction that nurses caring for patients during the day were at a higher risk for violence than at night when patients were sleeping. The exception was

with sun-downing patients who may have increased agitations at night when the agitation could be directed at the nurse (Ridenour et al., 2015). Other patients of concern for violence were individuals between the ages of 50 and 59 with a personality disorder. The researchers found a higher rate of physical aggression toward nurses (Ridenour et al., 2015). In the theory of planned behavior, if healthcare workers identify a patient as violent, the healthcare provider should work as a team with two or more individuals in the patient's room to reduce the risk of violence.

Effects of Violence on Healthcare Workers

Fernández-Castro et al. (2017) documented emotional exhaustion as an occurrence when staff members care for patients in high-stress areas. The study was conducted in a ward where the nurses did direct care and treatment. The number of unpredictable changes influenced fatigue in the anticipated care plan. Emotional exhaustion also contributed to increased fatigue. The study had a random sample of 113 nurses. Data were collected for a year by nurses answering questions programmed on cell phones that would alarm during the workday. The questions were adapted from the Maslach burnout inventory. The data were analyzed using SPSS linear regression multivariable modeling. The outcome concluded that the staff's ability to adapt to unexpected changes in the care plan would vary based on the staff's personal characteristics. There was an increase in the satisfaction of professional accomplishments when the healthcare worker accomplished a high demand task with the ability to have some control. Once again, the staff's personal characteristics affected the outcome influenced by emotional exhaustion (Fernández-Castro et al., 2017).

Another behavioral reaction to violence that appeared in the literature was normalizing or desensitizing. Normalizing can be influenced by a healthcare worker's perceptions of a peer's negative comments. Normalization has a negative connotation with the term "zero tolerance" for

violence (Geoffrion et al., 2015). Those who did not complain about workplace violence had a higher tolerance level, a higher level of trivializing, and a higher level of normalizing (Geoffrion et al., 2015) similar to the behavior seen in desensitizing.

Additional behaviors predicted to occur in staff when victimized included compromising job performance (Marshall et al., 2017), staff turnover, call-offs, less energy, fatigue, compromised patient care, and reduced engagement (Hamdan et al., 2017). Healthcare workers who have a heavier workload are at a higher risk for physical violence (Dal Pai et al., 2018). Experienced healthcare workers can become overconfident in their skills, putting themselves at risk for violence (McKeown et al., 2016). A witness to a peer's physical assault can have similar stressful, PTSD-type symptoms (Zhou et al., 2017). Females report more physical aggression than males (Ridenour et al., 2015). African American and Hispanic nurses reported less verbal aggression (Ridenour et al., 2015). Staff younger than 30 years old had more burnout because of less coping skills and experience (Hamdan et al., 2017).

In 2016, Haugvaldstad and Husum knew physical injuries would generally heal, but the psychological damage would have longer consequences. Common symptoms of emotional damage could be anger, anxiety, fear, loss of pride, guilt, and self-blame. There can be costly expenses with injuries and staff replacements. Staff's behavioral reactions of anger, anxiety, fear, and guilt, which would be expected and normal, can worsen patients' violent reactions. This emotional exhaustion, which can increase the need for greater control and confrontation, can be lessened by a mindful approach to developing an increase in empathy. Mindfulness can also reduce cortisol levels and improve interpersonal levels (Haugvaldstad & Husum, 2016).

Stevenson et al., in a qualitative study in 2015, observed that nurses' (N = 12) exposure to violent patients resulted in physical and psychological symptoms. The study was conducted

within the framework of primary, secondary, and tertiary prevention. Primary was the staff's protective reaction to the violence, for example, the fear that the violence would not be properly managed. Secondary was the immediate response and action in containing the violence. Tertiary was the follow-up management of staff's emotional and physical injuries, as staff went to peers or management for support. Psychological symptoms included anger, fear, anxiety, PTSD, guilt, shame, job dissatisfaction, and the desire to leave the job. The symptoms can be temporary or permanent. The accumulation of these stressors causes burnout related to personal job accomplishments and satisfaction. Also noted was that injured staff would care for themselves and not care for the patient escalating a violent event in addition to depersonalization or the inability to accept the problem of a violent patient as a responsibility. Staff may withdraw from violent patients and find support from peers in justifying reasons for avoiding the violent patient. Also, staff may blame the patient's violent behavior as a reason not to be responsible for providing appropriate care. This transfer of blame can cause guilt and shame that staff members do not want to discuss because it conflicts with professional goals. This adds to the depersonalization or feelings of being removed and not connected with the violent patient's care (Stevenson et al., 2015).

Jussab and Murphy (2015) used interpretive phenomenological assessment (IPA) by interviewing clinical psychologists ($N = 7$) in the relationship of the therapist's management of violence and their vulnerabilities. The researchers reported that one clinician had fears of vulnerability with loss of control, "freezing as a submissive dog" (p. 291). There was self-questioning of professional competencies with the realization that the therapeutic relationship was broken, causing an internal search on how to restore the relationship, which would eventually give way to self-protection. The two themes were the initial emotional reaction and

then the internal voices of rationalization after the violent event—a frustration of failure and self-defenses. Clinical psychologists also therapeutically work with other staff involved in violence and know staff can struggle with how others perceive their management of violence skills. Professional skills are questioned. The study compared and equated the violence healthcare workers were exposed to in hospitals with street violence. The emotional injuries were identified as depression, self-doubt, or anger and can be as damaging as physical injuries. Repeated exposure to violence can erode staff confidence and morale, causing burnout and staff fleeing from departments housing violent patients (Jussab & Murphy, 2015). The study recommendations included encouraging staff to allow for self-care, to recognize psychological injury, and to get help. Peers should provide support, listen to others who have been injured, and refuse to accept any level of violence as normal (Jussab & Murphy, 2015).

Additionally, a greater number of mental health individuals are in hospitals since the deinstitutionalization of mental health patients to the streets in the 1960s. Plus, there are not enough resources on the street to manage the disabled mental health individual with a higher risk for violence. Disabled mental health individuals have difficulty with communication, causing conflict. In order to be successful, staff will need to adapt to understand the patient's problems (Oxburgh et al., 2016). However, the staff's ability to be flexible and adjust to different patients' characteristics could delay appropriate treatment. Staff injury can result in emotional exhaustion and depersonalization.

Kerr et al. (2017) had contradicting findings when healthcare workers (N = 50) were exposed to neurosurgical patient violence. The staff took time off for physical injuries but not for psychological injuries. The researchers thought the staff might have had resilient factors or be desensitized to aggression. Causes may have been because peers or leadership were unsupportive

of psychological injuries. Normalizing the aggression of patients can be detrimental to healthcare workers' emotional states (Kerr et al., 2017). The researchers recommended interventions to assist staff in increasing awareness of their reactions to violence and to the danger of normalizing violence. After experiencing verbal abuse, leadership should advise the staff to react by exploring different methods. One method could be to huddle and discuss peer injuries and improved methods to manage the violent patient.

Abdul Rahman et al. (2016) studied work-related fatigue and psychosocial work stressors in the emergency room and critical care nurses (N = 201). A quantitative study using simple and multiple linear regression analyzed four variables related to workplace fatigue: burnout, self-reported health, commitment to the institution, and trust in management. Interestingly, job demand was not significant in any fatigue surveys. This was thought to be due to workers' commitment to the institution and the meaningfulness of the work. Factors increasing fatigue in nurses and healthcare workers were smoking, being single, and advanced age. Exercise was a contributor to reducing fatigue, but there was a misconception that exercise contributed to fatigue. Another misconception was that caffeine and smoking helped reduce the feeling of fatigue (Abdul Rahman et al., 2016).

De Souza Nogueira et al. (2018) compared burnout with the work environment by surveying nurses (N = 745) working in healthcare systems. They concluded in their study that there was no correlation between depersonalization and the work environment. Depersonalization was thought to be a protective factor for emotional exhaustion, a positive coping mechanism. However, according to the study, if that were true, it would be negatively associated with emotional exhaustion. Yet, in the survey, depersonalization had a positive association with emotional exhaustion (de Souza Nogueira et al., 2018). Therefore, the study

findings concluded that depersonalization was not a coping skill for emotional exhaustion but a separate characteristic.

Behavioral Adaptation

Nurses and healthcare workers benefit from yearly assaultive and self-defense training education. Nurses can prepare with improved communication skills using Habermas' communicative action theory, teaching "equal power, respect, open-mindedness" (McKeown et al., 2016, p. 571). Also, nurses can improve decision-making skills and teaching strategies. Healthcare workers can overcome difficulties in dealing with those in higher status and power. Effective leadership involvement improves teamwork relationships and reduces stress (McKeown et al., 2016).

To improve sensitivity, Ridenour et al. (2015) recommended keeping a daily inventory list of physical and psychological violence that occurred during the shift. This includes documentation of the personal feelings associated with the violent episode (Ridenour et al., 2015). Individuals should rate the violent episode as mild, moderate, or severe. It is also important to report severe physical and psychological aggression to leadership. Reporting the problems of violence improves leadership's awareness and ability to assist (Geoffrion et al., 2015).

Well-Being Supportive Interventions

Leadership can organize scheduled supportive interventions by building on staff's strengths in well-being programs, providing positive feedback, and getting involved with family support (Yragui et al., 2017). These interventions could benefit healthcare workers' job satisfaction with an improved sense of value. This support could aid healthcare workers in the

reduction of stress (Rossler, 2012) while improving skills to keep themselves and the patients safe.

Chapter Summary

A patient's ability to become violent can be sudden and unexpected, and a healthcare worker's behavior can be appropriate, overreactive, under reactive, or a failure to react. Healthcare workers are injured by exposure to confused and combative clients. These injuries include physical and psychological trauma to the healthcare worker, limiting the ability to provide patient care. The loss of a healthcare worker is expensive. Based on recommended interventions, healthcare workers' behavior can adapt to the care of violent patients resulting in improved injury prevention.

This DNP project identified if healthcare workers' exposure to violence had altered of job satisfaction levels, personalization, and fatigue with emotional exhaustion. Once levels of injuries were identified, would a therapeutic interventional group resolve and improve nursing and healthcare workers' effects from injuries? The outcome will provide better protection in reducing violent risks to healthcare workers.

Chapter 3: Research Method

This DNP project was developed following a report involving 17 staff injuries from a psychiatric department between July and October 2017. At that time, the safety committee at the hospital and the unit managers from the psychiatric department conducted a survey focused on the perception of safety on the psychiatric units. The Safety and Security Assessment of Behavioral Health was a tool developed by the managers to examine the staff's perception of safety (see Appendix A). The psychiatric healthcare workers completed the survey in January 2018. Following the survey, the hospital safety department concluded that the behavioral health staff perceived themselves to be safe, and they were adequately supported by the medical center. However, the conclusion did not answer the question as to why there was a rise in healthcare workers' injuries.

Purpose of the Study

The purpose was to determine if healthcare workers were becoming desensitized by frequent exposure to violent patients. This desensitization could cause healthcare workers to underestimate the personal effects. The project taught healthcare workers about the physiological responses to stress. The purpose was to determine if healthcare workers could benefit from practicing self-awareness, smooth rhythmic breathing, compassionate imagining, and having a safe place to process criticism.

Project Design

This DNP project was a quantitative design that followed up on the question of how healthcare workers' behavior was affected by violent patients. This project design was an evidence-based inquiry examining three physical reactions that can develop while working with negative, angry, and agitated high-risk patients. This project focused on emotional exhaustion,

depersonalization, and the lack of recognition of professional accomplishments. The hypothesis was that healthcare workers caring for confused, combative clients would have increased emotional exhaustion, depersonalization, and a lack of recognition of their professional accomplishments. Healthcare workers were surveyed with the Maslach Burnout Inventory Hospital Service Survey for Medical Personnel (MBI-HSS-MP) to determine baseline levels of emotional exhaustion, depersonalization, and a lack of recognition of their professional accomplishments (see Appendix B). A therapeutic intervention titled "A Survival Tool Kit While Working with Violent Patients" was presented. Four weeks after the therapeutic intervention, healthcare workers were resurveyed with the MBI-HSS-MP to determine the intervention benefit.

Research Plan

The research plan was based on a pre and posttest survey to determine the effectiveness of an intervention. The plan was to provide clear instructions for the MBI-HSS-MP. To avoid bias, no prior discussion about burnout as an outcome occurred. Participants were assured of confidentiality and anonymity regarding the information they contributed during the survey. Those who participated in the project did so on a strictly voluntary basis. Lunch was provided during a 30-minute presentation titled "A Survival Tool Kit While Working with Violent Patients." This presentation was created based on Fredrike Bannink's (2012) book, *Practicing Positive CBT: From Reducing Distress to Building Success*. The focus was on the importance of the healthcare worker's ability to recover and self-soothe following a violent event using compassion-focused therapy.

A PowerPoint intervention was used to regulate consistency with the anticipated multiple intervention presentations. The I-mood journal apps (see Appendix C) on a cellphone were

explained to aid in the development of self-awareness. The goal was that the outcome results would be useful in the daily huddle in community mental health centers as support for healthcare workers.

Data Analysis

The demographic information included the participant's age, gender, years of experience in healthcare, and prior injuries caused by clients and was assessed using Excel calculation for the mean scores. The MPI-HSS-MP information was analyzed using basic descriptive statistics as recommended by Mind Garden (Coultas, 2018) using mean and standard deviation scores. For the inferential comparison analysis, the paired sample *t* test was used.

Study Plan Activities

The participants completed the project consent and disclosure form. Then the participants completed a 5-point Likert scale to collect demographic data and the MBI-HSS-MP. A 30-minute PowerPoint intervention was presented. The project intervention provided descriptions to assess violent patients. The healthcare workers' reactions to a violent patient were also identified. Then using recommendations from Bannink's (2012) positive cognitive behavior therapy and Gilbert's (2014) compassion-focused therapy, a plan was presented to staff for self-recovery and self-soothing following a violent event (Bannink, 2012). The plan included self-awareness, soothing rhythmic breathing, compassionate focused imagining, and the creation of a safe place to process criticism. Participants were provided with a handout of the plan (see Appendix D). After four weeks, the participants repeated the MPI-HSS-MP to determine the intervention efficacy.

Instrument and Measurement Tools

The measurement tool was the MBI-HSS-MP. The MBI-HSS-MP is a 22-question tool divided into three parts focusing on emotional exhaustion, depersonalization, and professional accountability. The MBI-HSS-MP was developed in 1981 at the University of California, Berkeley. It is marketed by Mind Garden (Coultas, 2018), a publisher of psychological testing.

The MBI-HSS-MP has a reliability of 0.80 percent on emotional exhaustion. Depersonalization and professional accomplishments have a reliability rating of 0.70 percent. The validity of the tool is based on a variety of adaptations to specific occupations. This study used the MBI-HSS-MP, which was specifically adapted for medical professionals with the use of medical terminology. The MBI-HSS-MP explores the reasoning of "normalizing" inappropriate and violent behavior. The MBI-HSS-MP is grounded in a theoretical perspective that views burnout as a psychological response to the aspects of one's daily experiences.

According to Coultas (2018), the MBI-HSS-MP can confirm a relationship between job attributions and burnout. In a study of work stress effects, the MBI-HSS-MP was used with personality testing, and magnetic resonance imaging (MRI) studies documented that brain circuits could change, affecting the amygdala. These changes can interfere with an individual's ability to regulate their emotions and cause psychomotor slowing or fatigue (Coultas, 2018).

The survey tool was numerically coded, and the participants' names remained confidential, known only by me, the primary investigator. The codes will remain double-locked in a file for three years and then will be destroyed. A numeric code was placed on the pre- and post-MBI-HSS-MP to aid in data analysis and consistency for the surveyed information. The Mind Garden marketing company requested the MBI-HSS-MP tool not to be printed in the paper (Coultas, 2018).

Data Collection and Management

Data collection started with a one-week campaign to explain the purpose of the study and to invite staff to review the consent. The healthcare workers were provided with a consent form for voluntary participation in the project. The consent form explained the option to discontinue participation in the project at any time. It included a two-part questionnaire. The first part was to provide variable information, including age, gender, ethnicity, prior injuries, job title, and the number of years working in the medical field. Part two was a 22-question survey specifically related to emotional exhaustion, depersonalization, and professional accomplishments. Lunch was provided with a PowerPoint discussion on resources, including mindfulness, the cellphone application for I-mood journaling, and coping interventions. The data collected during the survey were calculated using Excel and SPSS. The MBI-HSS-MP took staff five to 10 minutes to complete. The MBI-HSS-MP was in paper format. The analysis scored emotional exhaustion, depersonalization, and personal accomplishments, calculating the means, median scores, and standard deviations.

The DNP project utilized a pretest and posttest design to study the effects of a therapeutic intervention. To test the power of the null hypothesis in a behavioral study, there would need to be 0.80 to reject the false null. Using Cohen tables, the project needs a sample size of 30 subjects (Kellar & Kelvin, 2013, pp. 109–110). After planning for incomplete surveys and staff dropouts, the sample size targeted $N = 50$ participants.

Methodology

This was a quantitative study on behavior adaptation modeled after evidence-based literature. The evidence review focused on healthcare workers' exposure, reaction, and recovery to violent clients. The review also collected evidence for management strategies and coping

interventions for violent patients. The DNP project started with a campaign on how to survive and recover while working with confused and combative clients. The format was a "lunch and learn" with discussion focused around providing resources to enable the healthcare workers' coping interventions related to emotional exhaustion. The setting was in the community and a community mental health center. The healthcare workers who volunteered were surveyed using the MBI-HSS-MP. The data were analyzed using a pretest and posttest survey format. The research question asked if there was stronger evidence of emotional exhaustion, disassociation, and lack of realizing professional accomplishments when the healthcare workers were exposed to violence. It was anticipated that methods used by healthcare workers to manage violent patients were influenced by the healthcare workers' emotional exhaustion, disassociation, and lack of recognition of professional accomplishments. Following the pretest survey using the MBI-HSS-MP, a series of coping interventions were discussed with the healthcare workers. Follow-up was four weeks after the intervention, and participants were contacted to repeat the MBI-HSS-MP.

Feasibility and Appropriateness

The risks to healthcare workers exposed to violence are increasing, and it is appropriate for healthcare workers to be aware of the physiological and psychological effects caused by the exposure to violent patients. It is appropriate for healthcare workers to look to leadership for support in policy and resources. This DNP project was appropriately based on evidence that would make recommendations to improve policy and interventions for the protection of healthcare workers caring for violent patients. The Occupational Safety and Health Administration, combined with state laws, are legislating safety plans for healthcare workers caring for violent patients. These laws require hospital compliance for the protection of

healthcare workers. This DNP project has provided evidence supporting the value of institutional financial commitment to safety plans and healthcare workers' safety education.

Institutional Review Board Approval and Process

The next process after committee approval was an application submission to the Abilene Christian University Institutional Review Board (IRB). The application for the IRB was in an electronic form designed to review the project research proposal, consent forms, recruitment materials, data collection instruments, and survey material (University of Texas at Austin, n.d.). The application was effective for one year, and any changes were to be resubmitted to the IRB. This DNP project was low risk for injury to the participants, and of the four types of applications, this DNP project qualified as exempt (see Appendix E).

Interprofessional Collaboration

This DNP project was coordinated with the collaboration of volunteer services, the chaplain, a social worker, and the community mental health center's administrative team. It was anticipated that the community center leaders would be interested in the project outcome and incorporate this evidence into policy to protect their healthcare workers. Outcomes and recommendations will be discussed with the leadership in safety committees.

Practice Setting

The MBI-HSS-MP was administered to community-based healthcare workers who provided care for confused and combative clients. The project was scheduled at the convenience of the community center. The project was conducted on a Monday following a staff meeting in the center's conference room. The 30-day follow-up was arranged before a Monday staff meeting in a conference room (see Appendix F).

Consent Procedure

The participants were informed that the study was voluntary, and all information collected would be confidential. The participants were told they had the right to withdraw from the DNP project survey at any point without repercussions. A copy of the consent form is in the appendix (see Appendix G).

Targeted Population

The targeted population was healthcare workers responsible for providing care for confused and combative clients. This population also included supportive staff who assisted with managing confused, combative clients such as chaplains, nurses, physicians, and security. Leadership and managers were included in the project, though they are not generally on the frontline managing violent patients. Leadership not on the frontline in caring for confused and combative clients frequently witness violence, and they would benefit from self-recovery skills.

Participant Recruitment

Participants for the DNP project were recruited several weeks prior to the intervention. A flyer (see Appendix H) with the date and time was distributed. Participants were given the opportunity to review the IRB approval letter and a copy of the volunteer participant consent. I explained that the research project was in conjunction with a doctorate in nursing practice graduate degree. I explained the information covered in the presentation. The participants were treated to lunch as appreciation for their time and assistance with the project. The participants were taught coping skills that could save their lives.

Participation Justification Numbers

The participation justification number was based on the Cohen tables to guarantee 0.80 reliability as required for mental health studies. The study size was targeted for 50 participants adding an allowance for incomplete surveys or participants withdrawing from the study.

Participant Demographics

The participants were healthcare workers from the community who were working in mental health centers, homes, and schools. They were both male and female adult participants over the age of 18. The participants included nurses, physicians, certified mental health workers, therapists, security, case managers, social workers, a chaplain, food service workers, mothers, husbands, daughters, and sons. These individuals provided healthcare for confused, combative clients, friends, and family.

Usage of Vulnerable Population

The vulnerable population, including children below the age of 18, was excluded. The survey was conducted in English. Prior injured healthcare workers were monitored for triggers.

Risks and Benefits

Associated Activity Risk of DNP Project

This study was a low physical risk DNP project designed to identify healthcare workers' levels of emotional exhaustion, depersonalization, and lack of realizing professional accomplishments. One possible risk could have been triggering individuals with a history of PTSD or depression caused by past trauma and injuries.

Mitigation of Associated Risk

At the time of the presentation, healthcare workers were monitored for triggering emotions. The plan was to direct triggered participating healthcare workers to speak with the project facilitator for referrals to employee assistance programs.

Benefits of the Study

Benefits would include safer healthcare workers with fewer injuries. Healthcare workers could increase job satisfaction with less fatigue. This DNP project could motivate the development of a team that could function with improved skills in the management of high-risk confused, combative clients.

Implications to Research and Nursing

This DNP project was designed to recognize that healthcare workers who care for confused and combative clients do experience emotional fatigue, depersonalization, and a poorer sense of professional accomplishment. This project presented an intervention with suggestions for self-recovery and self-soothing needed when caring for violent patients. The plan was for healthcare workers to benefit from interventional therapy, improved emotional fatigue, a sense of professional accomplishment, and improved depersonalization. There was a potential for policy development around specific support programs designed to aid healthcare workers caring for confused and combative clients, such as yearly programs for assault protection and personal injury prevention. Also, policy development could target security guards who assist healthcare workers in managing confused and combative clients.

Participants' Data Protection

The demographic information collected does not include names. Participants were assigned a code number. The key with collected survey information was stored in a locked

drawer in a locked office. The locations of the DNP project sites are confidential. There are no references to the names of the staff or clients. Examples of clients or healthcare workers used in the illustration or the applications of this project are fictitious and are not real occurrences.

Data Disclosure

The information collected during the MBI-HSS-MP for computer analysis was coded but not linked to individual names. Data from the paper surveys were double-locked in a file cabinet. The raw data will be stored as required by the IRB for three years following the project's completion.

Conflict of Interest

There were no conflicts of interest to report.

Timeline

After the DNP project proposal's defense and clearance from the IRB, the leaders at the community centers were contacted, and dates for the project lunch and intervention were arranged. After a period of four weeks following the initial lunch and presentation, a phone call was arranged for the follow-up assessment of the MBI-HSS-MP. The data were entered into the database and analyzed (see Appendix I).

Chapter Summary

This project was designed to survey healthcare workers' physiological and psychological reactions when exposed to violence. The project then evaluated the effectiveness of improving professional accomplishments, improved emotional energy, and improved personalization. It was anticipated that the DNP project findings would provide evidence to support the development of new methods to improve healthcare workers' self-recovery and self-soothing skills by using self-awareness phone apps, smooth rhythmic breathing, compassionate imagery, and a safe location

to process criticism. These interventions will promote safer healthcare workers and safer patients.

Chapter 4: Results

Community mental health centers that provide for the confused and combative client could not be successful without motivated, dedicated healthcare workers. These unique healthcare workers in the community setting face a challenging population. Healthcare workers are at risk for emotional exhaustion, disconnection, and lack a sense of professional accomplishment. Also alarming is the lack of self-care that healthcare workers invest in themselves (Baeza-Velasco et al., 2020). This DNP project investigated the community healthcare workers who daily risk their lives caring for confused and combative clients.

Research Questions

RQ1: Will community healthcare workers who care for confused and combative clients have emotional exhaustion, depersonalization, and a poor sense of professional accomplishment?

RQ2: Will community healthcare workers with emotional exhaustion, depersonalization, and a poor sense of professional accomplishments benefit from an intervention focused on self-care?

PICOT Research Focus

- Population (P): The population studied consisted of community healthcare workers caring for confused and combative clients. A total of 30 staff participated in a lunch and learn from the community. Of the original 30 participants, 26 participants were able to complete the posttest survey ($N = 26$).
- Intervention (I): The intervention demonstrated reasons and methods for healthcare workers to improve their self-care. I presented educational resources using a therapeutic PowerPoint presentation about the physiological harm of stress, which causes the release of adrenaline and cortisol. These stress hormones can precipitate medical conditions over

time that can be responsible for physical changes such as hypertension, headaches, arthritis, depression, anxiety, fatigue, gastroesophageal reflux disease, and other stress-related disorders. The presentation included the application of self-awareness specific to stressors by introducing I-mood apps. The intervention also educated the participants about the benefits of smooth rhythmic breathing, compassionate focused imagery, and the creation of a safe place to process criticism compassionately. For 30 days, the participants were encouraged to practice these four behavioral skills, and as a reminder, they were provided with an illustrated handout.

- Comparison (C): I qualified 30 community healthcare workers who were providing care for confused and combative clients. These participants were pretested using the MBI-HSS-MP and then they attended the intervention. After 30 days, the MBI-HSS-MP was repeated. The pretest and posttest surveys were compared for changes following the intervention.
- Outcome (O): The outcome was based on the comparison of the pre- and post-MBI-HSS-MP scores, which concluded there was an improvement in the MBI-HSS-MP postinterventional scores. It was anticipated that posttest survey scores would indicate self-awareness, smooth rhythmic breathing, compassionate focused imagery, and a safe place to process criticism. This approach would significantly improve emotional exhaustion, depersonalization, and professional accomplishments.
- Time (T): IRB approval was granted after 11 months on October 8, 2019. The first lunch and learn intervention was scheduled on December 16, 2019, and subsequent interventions occurred until there were 30 participants. Unfortunately, only 26

participants were able to complete the posttest survey. Research data collection was completed on April 16, 2020.

Project Analysis

Total costs for this DNP project included the MBI-HSS-MP tool, copy costs for the consent forms, a screening tool, and a postintervention handout flyer. Food was also provided for the lunch and learn. The cost for the MBI-HSS-MP tool was $2.50 a survey. However, I paid $2.00 per screen for 100 screens with a student discount for a total of $200.00. Photocopy costs, which included the consents to be signed by the participants, copies of the consents to be retained by me, 100 pretest and posttest survey screens, and 50 handout flyers, were $80.00. The cost of the "lunch and learn" food was $400.00. The total costs for the project were $680.00.

In addition to these costs, if the program were developed for a community center setting educational curriculum, the costs would also include the salaries of the healthcare workers, which could range from $27.00 to $33.00 per hour. Each time the program was presented in a community center setting with an average of 40 healthcare workers, the program's cost would be $2,000. The advantage of this financial investment is that it could save community centers money by improving healthcare worker retention, building staff longevity, and providing more experienced healthcare workers.

These costs can also be justified as the healthcare workers' emotional exhaustion is significantly improved. There would be fewer medical problems such as hypertension and anxiety-related gastrointestinal and arthritic pain that adds costs to the community healthcare system. Prevention is a cost-saving solution to illnesses. The outcome aim is to have healthier healthcare workers with better resilience and longevity. This would create a healthier workplace intellectually, mentally, emotionally, and physically.

The DNP project concluded that healthcare workers in the community who care for confused and combative clients experience emotional exhaustion and lack a sense of professional accomplishment. Emotional exhaustion depletes the positive, happier, hopeful, and successful energies that, when absent, results in fatigue and depression. Depersonalization was not an issue in this study, but it can cause a risk that would reduce the individual's ability to connect with other people and clients. The feeling or sense that there is a lack of accomplishment after a hard day of work reduces commitments to self-sufficiency. Self-awareness, breathing, imagery, or safety appears to be a waste of time. This information is necessary for the healthcare worker to renew and continue the commitment to self-care, which is the foundation for career longevity.

Healthcare workers under stress caring for confused and combative patients can contract damaging physical diseases. Healthcare workers need to be mindful of these physical risks and take recuperative steps to maintain their health. This project concluded that self-awareness, smooth rhythmic breathing, compassionate focused imagery, and a safe place to engage compassionately with criticism could reduce stress. Hypertension, insomnia, fatigue, poor concentration, irritability, and depression could thus be reduced. The participants practiced these recommendations for 30 days. When rescreened with the MBI-HSS-MP, the findings indicated that the participants' scores for emotional exhaustion, depersonalization, personal accomplishments, and depression had improved. Therefore, the DNP project concluded that the recommended interventions were successful, and individuals working with confused, combative clients could self-recover.

Discussion of Data

Cohen's table for 0.80 reliability recommended 30 participants in a mental health study. The project's planned to recruit 50 participants from a community mental health center. The plan

was to recruit enough participants to compensate for participant dropouts. This plan was not successful.

During the first intervention, there were 20 recruited participants invited with an actual attendance number of 14. On the thirteenth-day follow-up posttest meeting, three of the original 14 healthcare workers arrived for cupcakes and completed the posttest. An additional eight participants were individually contacted to complete the posttest. The last three participants were unable to complete the postsurvey because one participant was no longer employed at the community mental health center, one participant was ill, and one participant was unavailable (n = 11).

For the next intervention, another 16 community healthcare workers were recruited who qualified by providing care for confused and combative clients. They cared for family members, homeless adults, and special needs children. Some of these participants' clients had health conditions, including dementia with confusion and loss of memory. The client's confusion was worsened by medical conditions such as cancer or heart disease, both of which can cause hypoxia or chemical and enzyme imbalances. Confused and combative clients' diagnoses also included special needs children who had a range of conditions, including seizure disorder, schizophrenia, and conduct disorders with criminal records. All of these healthcare workers were at physical and emotional risk due to unpredictable behavior from their clients. Of the 16 participants who agreed to participate in the DNP project, 15 completed the pretest and posttest surveys with one dropout due to the death of her client, resulting in her decision to withdraw. The study's rate of retention was 86.6% (N = 26). The project failed to meet Cohen's table for reliability by not acquiring 30 participants.

Type of Statistical Analysis

Excel was used to calculate the demographic statistical central tendencies for the participant's age, gender, injuries, work experience, and years of experience. The gender mix results for the project were 54% female and 46% male (see Table 1). The participants' ages were 73% over 56 years old, 19% were 46–55 years old, and 8% were 20–34 years old (see Table 1). The reported history of prior injuries from confused and combative patients were 42.8% of women, and 25% of the men reported prior injuries (see Table 1). The participants' work experience background included healthcare workers and caregivers from mental health centers and other community settings. Healthcare workers and caregivers comprised 57.7% of the project participants. Healthcare management participants were 11.5%. Case managers and volunteer coordinators were 11.5%. Other participants included security, a chaplain, housekeeping, and food service, which comprised 19.3% (see Table 1). The participants' years of experience as healthcare workers were 38.5% with over 16 years of experience, 19% had 11 to 15 years of experience, 9% had six to 10 years of experience, and 23% had five years or less of experience (see Table 1).

Table 1

Demographics for Full Sample

Variable	Response	*n*	%
Age	20–34 years	2	7.7
	35–45 years	0	0.0
	46–55 years	5	19.2
	Over 56 years	19	73.1
Gender	Female	14	54.0
	Male	12	46.0
Prior Injury	Female	6	23.1
	Male	3	11.5
Years of Experience	Less than 5 years	6	23.1
	6–10 years	5	19.2
	11–15 years	5	19.2
	Over 16 years	10	38.5
Area of Experience	Healthcare worker	9	34.6
	Medical professional	6	23.1
	Case manager	2	7.7
	Management	3	11.5
	Volunteer manager	1	3.8
	Other	5	19.2

Data from the participants' responses to the pre- and post-MBI-HSS-MP surveys were then entered into SPSS by IBM. Raw scores were calculated for the mean or average and the standard deviation or the differences between the lowest and highest scores from the sample mean. Descriptive analysis was used to interpret the means and the standard deviation with the demographic information. The paired sample *t* test was used to compare the pretest and posttest surveys to find the inference data. The analysis focused on the pretest and posttest survey scores from these two groups. The same participants are the dependent variable, and they were used in both the pretest and posttest surveys. The same participants were tested twice. These qualified participants were community healthcare workers who cared for confused and combative clients.

Normal Ranges of Scores for the MBI-HSS-MP

- Emotional exhaustion: The numbers for interpretation were high scores of 27 and over, moderate scoring of 17 through 26, and low scores of zero through 16.
- Depersonalization: The numbers for interpretation were high scores of 13 or over, moderate scores were 7 through 12, and low scores were zero through six.
- Personal accomplishment: The interpretive scores were high scores of 39 or over, moderate 32 through 38, and low zero through 31. The values for the personal accomplishment scores were switched from ranking; therefore, a higher score on the posttest indicated an improvement in personal accomplishments.

The nature of the variable is ordinal or ranked. The variables are numeric with the use of the means and standard deviation. There were no outliers or scores that were bizarrely different from the other scores. The scores were normally distributed, and the data met the assumption: Will the intervention, plus 30 days to practice, reduce emotional exhaustion, depersonalization, and improve personal accomplishments?

There was one category for independent variables (IV), the prescreen and the postscreen. The inference analysis used the paired sample *t* test. The IV was the time between the prescreen and the postscreen. The dependent variable was the participants who were screened on two different occasions.

For emotional exhaustion, the paired sample *t* test compared the mean pretest and the mean posttest (see Table 2). The level of confidence was $p \leq .05$. The mean prescore was 20.88 (*SD* = 11.77), ranked as moderate, and the mean postscore was 13.53 (*SD* = 9.08), ranked as low. The $t = 2.784$ is larger than the critical value of 2.060 on the student's *t* distribution table. On the 95% confidential interval of the difference, the lower and upper values do not cross zero. There

was a significant increase from the pretest and the posttest, which indicates that there is a significant difference $t(25) = 2.78$, $p < .05$. Looking at the actual means of the pretest compared to the posttest, it is clear there was a decrease in emotional exhaustion following the intervention, concluding the intervention was successful (see Table 3).

Table 2

Paired Differences for Emotional Exhaustion

Item	Pair	*M*	*SD*	*SEM*	*Lower*	*Upper*	*t*	*DF*	*Sig (2-tailed)*
Pair 1	Pre-Post	7.3	13.4	2.6	1.9	12.8	2.8	25	.010

Note. There is a 95% confidence interval of the differences.

Table 3

Paired Statistics for Emotional Exhaustion

Item	Pair	*M*	*N*	*SD*	*SEM*
Pair 1	Pretest	20.9	26	11.77	2.3
	Posttest	13.5	26	9.09	1.8

For depersonalization, the paired sample *t* test compared the mean pretest and the mean posttest (see Table 4). The level of confidence was $p \leq .05$. The mean prescore was 5.35 (SD = 3.42), ranked as low, and the mean postscore was 4.73 (SD = 3.82), ranked as low. The t = .585 is larger than the critical value of 2.060 on the student's *t* distribution table. On the 95% confidence interval of the difference, the lower and upper values cross zero. There was no significant increase from the pretest and the posttest, which indicates that there was no significant difference $t(25) = 2.78$, $p \geq .05$. Looking at the actual means of the pretest compared

to the posttest, there was a slight decrease in depersonalization following the intervention concluding the intervention had some success (see Table 5).

Table 4

Paired Differences for Depersonalization

Item	Pair	*M*	*SD*	*SEM*	*Lower*	*Upper*	*t*	*DF*	*Sig (2-tailed)*
Pair 1	Pre-Post	.66	5.4	1.1	-1.5	2.8	.59	25	.56

Note. There is a 95% confidence interval of the differences.

Table 5

Paired Statistics for Depersonalization

Item	Pair	*M*	*N*	*SD*	*SEM*
Pair 1	Pretest	5.3	26	3.4	.67
	Posttest	4.7	26	3.8	.75

Depersonalization on the pretest survey was low, indicating that the participants felt connected to their clients. There was no posttest survey improvement. The outcome for the participants' professional accomplishments was ranked as low with slight improvement.

For personal accountability, the paired sample *t* test compared the mean pretest and posttest (see Table 6). The level of confidence was $p \leq .05$. The mean prescore was 35.23 (*SD* = 3.42), ranked as moderate, and the mean postscore was 35.69 (*SD* = 6.16), also ranked as moderate. The $t = .250$ which is larger than the critical value of 2.060 on the student's *t* distribution table. On the 95% confidence interval of the difference, the lower and upper values cross zero. There was no significant increase found from the pretest and the posttest, which

indicates there is no significant difference $t(25) = .250$, $p > .05$. Looking at the actual means of the pretest compared to the posttest, there was a slight increase in the posttest for personal accomplishments following the intervention, concluding the intervention had some success. The values on the personal accomplishment scores were switched from ranking; therefore, a higher score on the posttest indicated a slight improvement for personal accomplishments (see Table 7).

Table 6

Paired Differences for Professional Accomplishments

Item	Pair	*M*	*SD*	*SEM*	*Lower*	*Upper*	*t*	*DF*	*Sig (2-tailed)*
Pair 1	Pre-Post	-.46	9.4	1.8	-4.3	3.3	-.25	25	.81

Note. There is a 95% confidence interval of the differences.

Table 7

Paired Statistics for Professional Accomplishments

Item	Pair	*M*	*N*	*SD*	*SEM*
Pair 1	Pretest	35.2	26	7.9	1.5
	Posttest	35.7	26	6.2	1.2

Inference About Findings

If healthcare workers are aware of how stress can affect them physically, such as proper body mechanics preventing back injuries or using personal protective equipment (PPE) to prevent the spread of hepatitis or COVID-19, the outcome could save money. Community healthcare dollars could be saved by healthcare workers, resulting in extended productive and functional lives. Healthcare workers could avoid a future of hypertension, headaches, and arthritis. Promotions to reduce stress, common in healthcare workers, should be mandated.

Hospitals and community centers could start by creating safe, stress-free rooms with beautiful pictures or garden environments to create calmness.

Summary of Strengths and Weaknesses

The strengths of this DNP project include the use of the MBI-HSS-MP tool, the willingness of the community mental health center's participation, and the outcome, which supports the hypothesis and voids the null hypothesis.

- $H1_o$: Do healthcare workers who care for confused and combative patients have higher levels of emotional exhaustion, depersonalization, and a poorer sense of personal accomplishments?
- $H1_a$: Do healthcare workers who care for confused and combative patients have normal or low levels of emotional exhaustion and depersonalization with a good sense of personal accomplishments?
- $H2_o$: Could healthcare workers benefit from increased resources and interventions that could improve levels of emotional exhaustion, depersonalization, and personal accomplishments?
- $H2_a$: Would healthcare workers show no benefit from increased resources and interventions that raise levels of emotional exhaustion, depersonalization, and a sense of personal accomplishments?

Strengths also included the community mental health center's willingness to be transparent and allowing me as a non-staff member to step in to conduct research with their staff and healthcare workers. This transparency allowed for a study outcome with information and recommendations for the community in developing approaches to prepare better healthcare workers in high-risk areas with clients who are confused and combative.

Weaknesses included difficulty in recruiting participants, the difficulty in completing post surveys, and the difficulty in keeping the project quantitative versus qualitative. Recruitment was difficult because the healthcare workers who provided care for the homeless in the community mental health centers were social workers, chaplains, administrators, maintenance workers, security, dietitians, and housekeepers. Many of the healthcare workers were in residence at the homeless shelter, earning privileges for better dorm rooms and food. Those in charge of mealtimes and programing for the shelter clients were frequent volunteers from high school and college students or individuals with court-appointed service hours. As the primary investigator, I also saw firsthand that even a healthcare worker could be confused and combative. This was witnessed when a spoon was jerked out of the volunteer's hand by a frustrated healthcare worker on a meal service line. The DNP project intervention had been prepared for college-level healthcare workers, and the intervention at the time of presentation had to be modified to adjust for improved audience comprehension.

Participants in this quantitative study wanted to discuss and have the opportunity to express their concerns. However, I was not prepared to answer personal questions, such as "Why when we take the homeless to the hospital for medical treatment are hospital staff negative toward homeless individuals?" or "My daughter is schizophrenic. How can I ever learn to adjust and not be upset?" These were questions I had not prepared to address because the plan was to focus on tools that could assist with surviving difficult situations, not therapy. The questions asked about the medical system's lack of acceptance for the homeless or the lack of support for families caring for their sick loved ones. This would require a deeper level of therapy not designed for this project. However, it was clear the healthcare workers wanted time to talk about their difficult responsibilities with clients.

Recommendations for Future Projects

Future recommendations for this type of DNP project could include additional discussions about different coping skills, a larger study with more participants, and a project intervention better adapted to the community mental health center's healthcare workers. Different coping skills that were suggested at the time of the intervention by participants included meditation, exercise, diet, and prayer. A larger study would improve the reliability outcome to strengthen the proposal for hospital administrators to develop better emotional and personal satisfaction programs for healthcare workers. Interventions could benefit and improve professional accomplishments.

Additionally, research could include the effects of healthcare workers who struggled to relate to their client's confused and combative behavior. This project found that healthcare workers connected with their clients, but there were different views. Some healthcare workers cited that their lack of connection caused them to feel inadequate; for example, trying to convince a confused patient to bathe. These healthcare workers struggled to keep clients safe, and the client did not appreciate the effort. Another concern is the client's inability to recover, which limits the control of the healthcare workers to manage positive outcomes. This negative impact on the healthcare worker should be researched.

Implications for Future Projects

Unprepared healthcare workers in the community centers could slow the progress of the healthcare system's move to a community home center model. Future projects could improve data collection in community mental health centers by using different survey tools such as the Copenhagen burnout inventory. The advantage of the Copenhagen burnout inventory is that it measures a participant's personal life, including relationship stressors and health stressors.

Surveying different aspects of healthcare workers' lives would provide more appropriate interventions (Grigorescu et al., 2018).

Healthcare workers need time to share what they are experiencing. The MBI-HSS-MP questions stimulated conversation. Participants wanted to explain and discuss their responses to the survey questions. The survey tool became an intervention; for example, when the participants were asked if they were physically drained from their work, they would want to explain why. Future researchers should explore providing discussion time when asking survey questions that are as thought-provoking as the intervention.

Discussion of Limits Related to the Project

The limitations included the time of the year the project was conducted, the COVID-19 pandemic, and the participants' educational levels. The DNP project was started prior to the end of December with participants' comments that stress was higher due to the timing of the upcoming holidays. The postscreens were conducted during the COVID-19 pandemic, affecting stress levels in the care of clients due to a high risk of COVID-19. Some participants reported they had been separated from their clients due to contamination risks and were feeling more rested being shut in their homes due to concerns of COVID-19.

Other limitations included the project's intervention was created for college graduate-level healthcare workers. There were details about the body stress hormones cortisol and adrenalin when elevated during longer than normal times, causing physical harm. The intervention presentation had to be scaled back for the community setting, where there were cultural and educational background differences.

The DNP project lacked a control group, and the project had a small number of study participants. It is difficult to conclude if the intervention was the cause of the significant increase in the improvement of emotional exhaustion due to pre-Christmas stress and COVID-19 stress.

Chapter Summary

The DNP project confirmed that healthcare workers did have emotional exhaustion and lacked a sense of personal accomplishment. In this project, depersonalization was not an issue. The project presented an intervention on self-awareness, smooth rhythmic breathing, compassionate focused imagery, and a safe place to process criticism compassionately, which improved post-MBI-HSS-MP scores for emotional exhaustion. This indicates that healthcare workers with confused and combative clients would benefit from support and resources. The project also found only a slight improvement after the intervention for the healthcare workers' perceived professional accomplishments. The survey scores remained at moderate risk. Additional research and implementations would be needed to address this risk.

Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this DNP project was to understand better the effects of confused and combative clients in the community setting on healthcare workers. The project had anticipated finding community healthcare workers with emotional exhaustion, depersonalization, and missing a sense of professional accomplishment. The project's intervention provided instructions on the use of self-awareness using a personal device application, breathing exercises, compassionate guided imagery, and a safe place for recovery. The goal of the interventions was to provide healthcare workers with inexpensive, easily accessible methods for stress reduction. Complicating stressors for the community healthcare workers are the characteristics of clients who are resistant in care and whose confusion does not provide positive or helpful feedback.

Commonly, healthcare workers are physically injured when clients pinch, kick, spit, and hit. Too often, the healthcare worker's efforts, energies, and intelligence are not appreciated by the clients and are missed by coworkers, managers, and themselves. Additionally, healthcare workers tend to be too busy, moving on to the next task and fail to self-assess for personal injuries. Over time, this unrecognized stress produces physical changes such as hypertension and overweight issues leading to poor self-esteem, diabetes, arthritis, depression, and more. This DNP project stressed the importance of self-awareness and recovery in a project using a quantitative research approach. However, when considering other options for projects, a qualitative study could provide the opportunity to connect with participants by building connections by verbally engaging the healthcare worker in a discussion about the awareness of challenges in caring for confused, combative clients and the importance of self-recovery.

Interpretation of Findings

Healthcare workers in this DNP project responded positively to the attention they received during the intervention. The participants appreciated the recognition for accomplishing a difficult task with the opportunity to discuss their struggles. This was not the intended objective of this DNP project, but I realized the healthcare workers took advantage of the opportunity to verbalize their frustrations. I realized that healthcare workers blamed themselves for poor outcomes. At the 30-day follow-up screening, the healthcare workers anticipated another opportunity to discuss what they had learned about themselves. One participant commented that her sleep had improved with the breathing exercises. Another participant realized that due to the COVID-19 mandated separation from her mother, who was in a nursing home, she was getting more rest, and her emotions were not as negative. Many participants in the DNP project spoke about surviving with spiritual interventions.

Inference About the Findings

The emotional exhaustion score for the community population was moderate and improved with the intervention of self-awareness, smooth rhythmic breathing, compassionate positive imagery, and a safe location. Participants were excited to talk about their safe space in a garden or the corner of the room where they could go to meditate and pray. One participant was surprised to discover that as she was busy caring for her 100-year-old confused mother and her schizophrenic daughter that she missed caring for herself. COVID-19 had forced her to stop and rest. She felt better, happier, and less depressed.

Depersonalization was low since many of the participants were residents in the community working to care for their peers. The care these healthcare workers provided for their peers helped to cover benefits for nicer shelter rooms. These healthcare workers could identify

with their clients. Many community research participants were caring for their mothers, wives, children, fathers, and husbands. This population of community healthcare workers was connected to their clients.

Professional accomplishments scored moderately and were a concern for burnout. The intervention was not effective in building healthcare workers' sense of professional accomplishments. The study conclusion displayed that the intervention was not designed to address the problems of a poor sense of professional accomplishments. There would need to be a different intervention to focus on the pride in a job accomplished.

Implications of Analysis for Leaders

Evidence from this project and research confirms the need for leadership's response to healthcare workers caring for confused and combative clients. The damages of emotional exhaustion, missing personal connectivity, and poor self-evaluation for personal accomplishment should be identified. Leadership should provide programing and incentives to address the risks that are associated with healthcare workers providing care for confused and combative clients. Services might include worksite yoga and computer programs, reminding healthcare workers to do deep breathing exercises. Leaders can role model nurturing skills and organize safe spaces for recovery. Leadership can connect with healthcare workers and provide feedback, building new levels of professional accomplishments. This may include recognition of the high achievers but also recognition of healthcare workers burned out and affected by emotional exhaustion, depression, or issues of depersonalization. Studies and questionnaires could assist the leadership in identifying the types of support needed for their healthcare workers.

Evidenced-Based Practice Findings and Relationship to DNP Essentials (I-VIII)

Evidenced-based practice findings confirm that healthcare workers in the care of confused and combative clients have emotional exhaustion, depersonalization, and a poor sense of personal accomplishments. Complications of these issues include expensive loss of healthcare workers, burnout, healthcare worker shortage, increased sick calls, and early retirement. Evidence suggests that improved retention of healthcare workers could be accomplished by emotionally supporting healthcare workers, recognizing the need for connection, and allowing healthcare workers to take pride in personal accomplishments (Yu et al., 2019). The standards for the doctorate in nursing practice foundational competencies are described in eight essential components.

Essential I: Scientific Underpinnings for Practice

This DNP project collected scientific data using the MBI-HSS-MP tool and identified the effects of stress on healthcare workers resulting in emotional exhaustion, depersonalization, and a poor sense of personal accomplishments. The project intervention promoted self-awareness, smooth rhythmic breathing techniques, compassionate imagery, and a safe place to engage compassionately. The study's participants practiced these interventions and were rescreened with the MBI-HSS-MP after 30 days. There was an improvement in scores for less emotional exhaustion. This would be applicable to the "processes that affect positive changes in health status" (Chism, 2013, p. 15).

Essential II: Organizational and System Leadership for Quality Improvement and Systems Improvement

The DNP practitioner will develop care delivery to meet the needs of the population by preparing healthcare workers to manage confused and combative clients better. The application

could include the education of healthcare workers to understand the risks to their health when caring for difficult noncompliant clients. Clients, when sick, may not be cooperative or appreciative. A client's altered mental status places the healthcare worker at emotional and physical risk to be pushed, pinched, bitten, kicked, jerked, or more. Doctorate in nursing practice scholars should prepare healthcare workers with skills in self-protection and self-recovery (Fischer et al., 2018).

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

Evidence indicates that community centers do provide better healthcare delivery at less cost for long-term chronically ill clients, such as those with mental health issues. Evidence indicates that community healthcare workers are experiencing burnout (Kranz et al., 2020). These healthcare workers could benefit from the evidence that mindfulness, smooth rhythmic breathing, compassionate imagery, and a safe location can reduce stress.

Essential IV: Information Systems-Technology and Patient Care Technology for the Improvement and Transformation of Healthcare

This project promoted I-mood apps (see Appendix C), allowing participants the opportunity to set a chime to ring at their designated daily time to check-in and self-assess their moods. The I-mood apps track the history of a participant's moods, indicating the need for coping skills implementation. A healthy healthcare worker with less stress can provide better care for the client.

Essential V: Healthcare Policy for Advocacy in Healthcare

This DNP project displayed the need for community mental health clinics to advocate for improved funding and resources and set up forums to allow clients to speak directly to developing councils as they create healthcare budgets and healthcare centers. There is a need to

advocate for better home centers with healthcare, food, lodging, and therapy. Additionally, advocacy is needed to support healthy, safe healthcare workers.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

In the community, there are needs for case managers, legal advice, dentists, dermatologists, mental health referrals, and routine care, including clothing, work opportunities, and spiritual growth. Security and safety are a necessity within the growing community, as the drug and alcohol pandemic targets the vulnerable homeless population.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

It is essential to promote health and to reduce the risks of disease by encouraging healthcare workers that good health begins with the healthcare workers. The management of personnel stress while caring for confused and combative clients can reduce psychological and physiological illnesses such as hypertension, arthritis, intestinal disorders, depression, and suicidal ideation.

Essential VIII: Advanced Nurse Practice

The DNP is responsible for educating, mentoring, connecting, and emotionally assisting healthcare workers and to inspire pride in personal accomplishments. The DNP professional's role would be to live and practice a healthier life while caring for confused and combative clients.

Recommendations

Future healthcare models will focus on the establishment of community home centers (Kranz et al., 2020). Studies will determine the funding, population focus, priorities in medical treatments, and what preparation is needed for the healthcare workers located in the community.

This DNP project had the opportunity to interview healthcare workers at the community level in a mental health center. The healthcare workers were older individuals with limited healthcare skills requiring the center to transport ill clients to hospital centers. The center's focus for mental health was to provide basic needs such as first aid, food, shelter, and therapy. The centers need an advocate who can develop better policy and funding to support community healthcare workers. New policies should include important factors that will improve emotional exhaustion, depersonalization, and professional accomplishments for healthcare workers to avoid burnout and the community's loss of the workforce. This includes a workforce that is needed to care for confused and combative patients.

Recommendations for Future Research

Recommendations for future research include focused evaluation of healthcare workers who elect to care for confused and combative clients and work in community mental health centers. Recommendations include a need for a better understanding of how to improve the educational institutions that prepare healthcare workers caring for a population of confused and combative clients. Also, I would research the community center's awareness of the type of system needed to best support healthcare workers' safety. I would learn how to building a sense of improved professional accomplishments in healthcare workers to reduce stress and burnout. I would investigate what behaviors, such as keeping lists of professional recognitions, healthcare workers value.

Clinical Practice Summary

The DNP project, which focused on community healthcare workers, was successful in identifying the need for emotional support and building a sense of professional accomplishments. The project found that mindfulness, smooth rhythmic breathing, compassionate imagery, and a

safe place improved emotional exhaustion. The project intervention did not improve building a sense of professional accomplishment. Leadership and educational institutions would benefit from projects that provide information about emotional injuries and a poor sense of personal accomplishments caused by confused and combative clients. Because of these learned restorative behaviors, healthcare workers can improve their emotional energy. With this renewed emotional energy, healthcare workers could prevent physiological and psychological injuries.

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Appendix A: Safety and Security Assessment of Behavior Health

On a scale of 1-10 (1 is the lowest negative response and 10 the most positive response)

1. I feel safe when I am working in the behavior health department.
2. I know what to do if I encounter a situation that makes me feel unsafe while working.
3. I have had adequate safety training from the medical center.
4. The medical center is committed to workplace safety.
5. My supervisor or manager is actively involved in keeping the workplace safe.
6. I feel that workplace safety issues are investigated properly.
7. I am familiar with the medical center's policy on workplace violence.
8. The security staff participates effectively in code situations.
9. The people I work with (your coworkers) function well as a team in assaultive situations.
10. After an assault occurs, there is an effective debriefing that helps improve our process.
11. How long have you worked for the organization?
12. Are there any perceived barriers that you come across when trying to work safely or reporting safety issues to management?

Appendix B: Maslach Burnout Inventory-Health Service Survey-Medical Personnel Tool

Purchase Agreement

Maslach Burnout Inventory™

Instruments and Scoring Keys

Includes MBI Forms:

Human Services - MBI-HSS
Medical Personnel - MBI-HSS (MP)
Educators - MBI-ES
General - MBI-GS
Students - MBI-GS (S)

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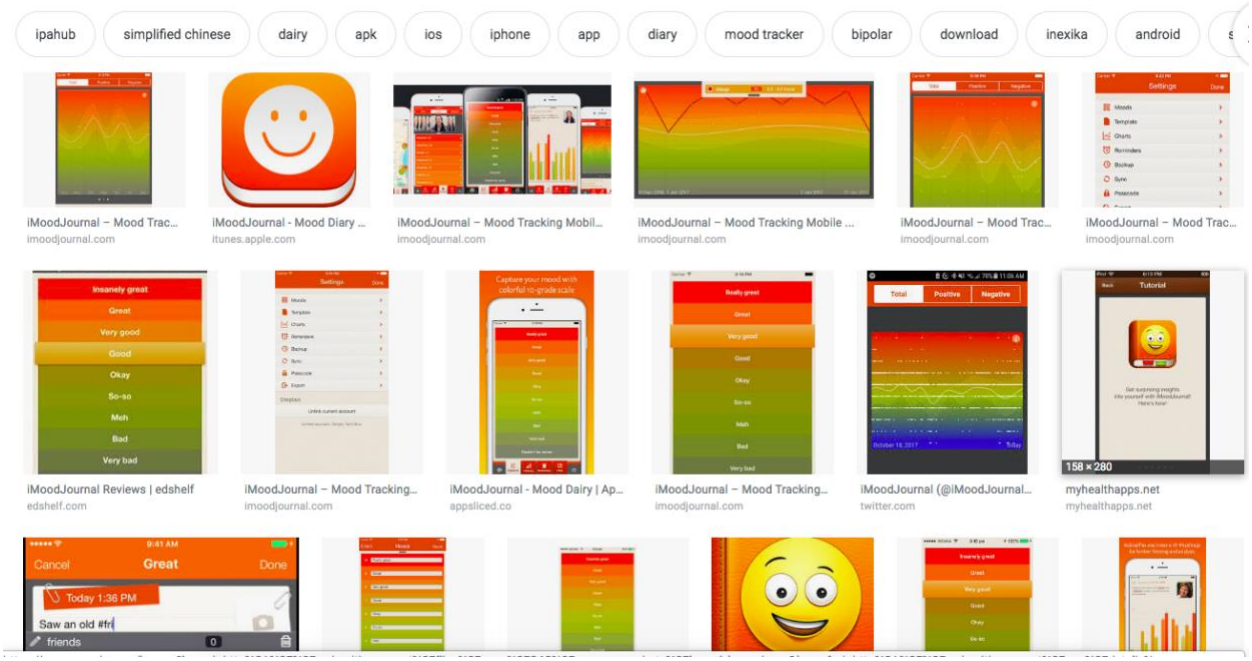
Appendix C: I Mood Journal Apps



Appendix D: Handout for Participants

Appendix E: IRB Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

October 8, 2019

Department of Nursing

Abilene Christian University

Dear

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled "Protecting Healthcare Workers from Violence,

(IRB# 19-069)is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

, Ph.D.
Director of Research and Sponsored Programs

Appendix F: Institutional Invitation and Support Letter

Monday, December 9 at Noon would work best for . I believe 14 – 15 staff will be present.

We meet in a conference room located in front office area. Our address is

Approximately 1 mile There is a sign out front, driveway just past the sign, on right.

Guard Shack will direct you to the front office.

Parking in front of multi office area.

I look forward to meeting you and your presentation!

Many blessings!

Appendix G: Participant Recruitment Flyer

Participant recruitment

Participants for the DNP project will be recruited prior to the intervention. An invitational flyer with the date and time will be distributed. Participants will be given the opportunity to review the IRB approval letter and a copy of the volunteer participant consent for review. The primary investigator will explain the research project is in conjunction with a doctorate in nurse practice graduate degree. The project will discuss methods of coping with violent patients and what interferes with the recognition of a violent patient causing venerability for healthcare workers and the benefit of methods to self-recovery or self-sooth. The project intervention will provide lunch and will conduct the survey (MBI-HSS-MP) or pretest and a presentation of the project intervention, “A survival tool kit when working with violent patients.”

Appendix H: Project Timeline and Task List

Investigate community locations to conduct the project	August–November 2019
Purchase use of tool MBI-HSS-MP	November 2019
Arrangement (dates and times) for presentation	November 2019–March 2020
Conduct presurvey and interventions	December 2019–March 2020
Conduct postsurvey (30 days from presurvey)	January–April 2020
Evaluation of data	April–May 2020
Presentation of survey results to ACU	June 11, 2020–July 2020
Presentation of survey results online (not in conference due to COVID-19)	August 2020
Press release	September 2020
Submit paper for publishing	December 2020