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Royal College of Surgeons in Ireland

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Declaration:

“I hereby certify that this material, which I now submit for assessment for the Project Dissertation Module on the Msc in Healthcare management is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.”

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## Abstract

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Abstract
This change initiative sought to ensure the development of confident and competent nursing staff capable of effectively deescalating potentially aggressive episodes. The initiative was developed in response to feedback given by nursing staff working in an acute mental health setting regarding their concern in relation to their confidence in deescalating potentially aggressive episodes. The author identified utilising educational groups on de-escalation as a method of improving nursing staff confidence. This change initiative will focus on the development and evaluation of educational groups based on the “Talk Downs” model, as a means of developing the nursing staff confidence when faced with potentially aggressive episodes (L. Bowers, 2014).

The author facilitated implementing this change initiative utilising the HSE change model (The Organization Development and Design Unit, 2008). The initiative follows the four main steps of initiation, planning, implementing and maintaining. The author then uses this model to effectively develop and implement his change. The author then evaluates the change initiative utilising Kirkpatrick’s (Kirkpatrick, 2001) model of learning. The author structured his evaluation plan using the four levels of Reaction, Learning, Behaviour and Results in Kirkpatrick’s model to identify if the initiative has been effective.
Acknowledgements:

I would like to thank everyone that supported me throughout this change initiative. I would especially like to thank my programme directors both Steve Pitman and Theresa Kane, my supervisor Grace Bloomer and my colleagues in the action learning sets for all the helpful direction and advice on my initiative. Furthermore I would also like to thank Adam Kavanagh the Clinical Nurse Education Coordinator within my work environment for all his help support and direction on a variety of different aspects of my initiative throughout the year. I would also like to thank all the nurses that participated in the educational groups your input was invaluable. An also the Clinical nurse managers that provided them with the time to attend the group.

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Chapter 1 - Introduction

1.1 Introduction

Managing aggressive incidents is a difficult and challenging experience for all staff nurses (Martin, T., & Daffern, M. 2006). The importance of developing interventions to manage aggression and reducing coercive interventions like restraint and seclusion is well documented. Throughout the literature, conflicting opinions are evident of which strategies will effectively reduce the requirement for these coercive interventions (Mental Health Commission 2013) (Bowers, L., Whittington, R., Nolan, et al. 2007) (Bowers, L., Crowhurst, N., Alexander, J., et al 2002) An important aspect of these strategies highlighted is the ability of the staff to deescalate the situation, however within the literature there is no definitive description of what de-escalating a situation entails (Price, O., & Baker, J. 2012). It is highlighted that for a person to de-escalate an aggressive episode there are many aspects that need to be considered (Price, O., & Baker, J. 2012). In response the author aimed to investigate this topic further and establish a method to improve staff confidence in deescalating potentially aggressive episodes.

The author’s project is titled “An evaluation of the impact of the Talk downs model on self-perceived confidence of Nurses for de-escalating potential aggressive episodes. Within this chapter the author gives an overview of the complete project highlighting the aims, objectives, rationale, and the methods of the evaluation. Following this chapter the author discusses the literature review, the aim in this review was to define the change initiative and gain direction, focus and solutions to various challenges within the change initiative. The author will discuss how he implemented
his change initiative and the various challenges he experienced within the process. The author was guided throughout his change initiative by the steps in the Health Service Executive (HSE) Change Model (The Organization Development and Design Unit. 2008). In chapter 4 the author discussed how he evaluated his initiative utilising Kirkpatrick’s model of evaluation to ensure his initiative is completely and effectively evaluated (Kirkpatrick, D. L. 1996). The final chapter reviews the results from the organizational change initiative discussing the impact and possible strengths and limitations of the organizational change initiative.

1.2 Ethical Approval.

The author referred to the ethical guidelines of both the Royal College of Surgeons in Ireland (RCSI) and of the authors’ place of work prior to commencing his organization change project (Royal College of Surgeons, 2016). The author was required to complete an application form and submit it to the Research Ethics Committee within the organization he works for review to ensure that there are no ethical issues present which would negatively influence participants.

1.3 Rationale for Carrying out the Change.

The author as a Clinical Nurse Manager 1 on a busy acute mental health ward has seen and experienced first-hand the various difficulties staff nurses face in managing aggressive episodes. Thus he understands that for a nurse to successfully de-escalate an aggressive episode there are many variables that the nurse needs to consider and be aware of to ensure a successful outcome. It is clear to the author that the nurse not only needs to be confident within their environment, but also in
their ability to de-escalate these potentially aggressive episodes. The author discussed these topics with his fellow colleagues highlighting the importance of restraint reduction, assessing possible interventions for reducing the need for restraint and discussing staff’s confidence in using these interventions. The author’s colleagues identified that staff’s ability to de-escalate a potentially aggressive episode varies due to many different factors, one of these factors most evident is the staff member’s confidence and experience.

As a result, the author was concerned at the nursing staff’s perceived lack of knowledge and confidence in their ability to de-escalate a potentially aggressive episode without resorting to restraint. In response the author discussed possible effective interventions with staff, many highlighted the need to gain an understanding of how to de-escalate situations. A number of staff felt that the ability to de-escalate a potentially aggressive episode is due to experience and the nurse’s personality. Thus the author began investigating methods to aid in improving the confidence and knowledge of nursing staff in de-escalating potentially aggressive episodes.

The importance of effective management of aggression has been highlighted by The Mental Health Commission (2013), who discussed the importance of developing interventions for reducing the dependence of service’s on the use of restraint and seclusion in the management of aggression. They discuss the importance of leadership, debrief and on-going education to provide for continuing development of staff in managing aggression (Mental Health Commission 2013). Price et al. (2015) develops this concept discussing the importance of de-escalation training as a
means of developing positive staff attitudes towards service users, and similarly in providing staff with a better understanding of how to approach potentially aggressive situations. Within the model “Safe Wards” the importance of how staff view service users is discussed further highlighting its importance in managing conflict on a ward (Bowers, L. 2014). They highlight that staff often resort to containment interventions such as restraint, higher observations and over use of medication, which can result in an increased resentment from service users towards the individual that they view as imposing the containment on them (Bowers, L. 2014). Within “Safe Wards” they developed a model for deescalating aggressive situations called “Talk Downs” (Bowers, L. 2014). Within this Bowers (2014) provides a guide on how to train and develop staff understanding on how to deescalate aggressive episodes (Appendix 1).

Thus the author aims to implement educational sessions on guiding staff on de-escalating potentially aggressive episodes using the “Talk downs” model developed by Bowers, L. (2015). The author hopes that this intervention will feed in to the overall aim of the mental health commissions aim of reducing the levels of Physical restraint required and that this initiative may form as part of an overall restraint reduction strategy (Mental Health Comission, 2013).
1.4 Aims & Objectives

Aim:

The aim of this study is to investigate whether implementing educational groups using the “Talk Downs”, model of de-escalation, will positively influence self-perceived confidence of nurses in de-escalating potentially aggressive episodes.

Objectives:

- Facilitate 6 educational sessions for ward based nurses’ over a five week period beginning on the 6th of April.
- Survey the participant’s self-perceived confidence in de-escalating potentially aggressive episodes prior to and after each educational group.
- Establish over the six educational groups if the content of the module is sufficient in this format to positively influence self-perceived confidence of staff nurses in de-escalating potentially aggressive episodes.

1.5 Evaluation.

Evaluation forms a key part of any change initiative as without evaluating an initiative then we cannot tell if it is effective (Handy, C. 1999). The author aims to completely and effectively evaluate his initiative using the levels identified by Kirkpatrick (Kirkpatrick, D. L. 1996). To achieve this goal the author intends to utilise two approaches, initially using a pre and post-test survey and contrasting the results to
identify changes in the participant’s self-confidence in deescalating potential aggressive episodes.

On review of the literature the author discovered a difficulty in assessing levels of staff confidence noting a number of different assessment tools that could be utilised to assess staff nurses confidence when managing aggression (Thackrey, M. 1987) (Lowe, K., Jones, E., et al 2007). In exploring the literature the author identified that Thackrey’s assessment questionnaire “Clinical Confidence in Coping with Patient Aggression” is used quite extensively in the literature with numerous articles using it as their main assessment instrument (Thackrey, M. 1987) (Martin, T., & Daffern, M. 2006) (Needham, I., Abderhalden, C., et al et al 2005). Therefore the author aims to establish utilizing Thackrey’s questionnaire, the levels of confidence of nursing staff prior to attending the educational groups (Thackrey, M. 1987) Then the author will reassess the levels of confidence of the nursing staff again utilizing Thackrey’s questionnaire, following the educational group to assess if the nursing staff perceive an increase in confidence when attempting to deescalate a potentially aggressive episode (Appendix 2).

The author hopes that this strategy will aid in identifying the nursing staff's reaction to the educational groups and level of confidence gained within the educational groups. However it is important to state that the changes in the behaviour are as a result of the educational groups is a more challenging as it requires a more scientific approach over a longer period of time to ensure reliability of the results (Kirkpatrick, D. L. 1996). The author hopes he can review this level of learning during his
attempts to develop his initiative, as he will meet with various participants that took part in the initial initiative and discuss how it can be developed to become part of the authors work environment. The author will be able to review the improvement in enthusiasm to develop nursing staff confidence to deescalate potentially aggressive episodes.

The author hopes that the overall aim of this initiative will be a reduction in the requirement of restraint, however to evaluate this requires it to be reviewed over an extended period of time. (Kirkpatrick, D. L. 1996) inform us that the behaviour level, the results level are difficult level’s to evaluate. However the author is hopeful that by aiding in the reduction of restraint this will result in other beneficial factors for the organization that the author works such as reduced absenteeism, lower costs and increased morale among the nursing staff.

1.6 Summary.

There are many difficulties in managing aggressive episodes, as often service users that are aggressive are unpredictable and impulsive thus often need to be approached in unique and different ways (Rippon, T. J. 2000). Thus the author aimed to encourage the development of staff in managing aggressive episodes by providing educational groups on de-escalation. The author worked with various stakeholders initially to develop an understanding of why the introduction of educational groups on de-escalation would be beneficial. To do this the author utilised various committee’s that had been set up within his work environment such as the restraint reduction committee and the clinical nurse managers committee. The author worked closely
with the clinical nurse education co-coordinator in his work environment as he was aware of the hospital’s aim to introduce an overall strategy of reducing restraint that was been led by the clinical nurse education co-ordinator. The author's initiative is very much consistent with the aims of this strategy, thus author worked with his Clinical nurse education coordinator to aid in gaining buy in from the senior management and to create urgency within the authors work environment by utilising the rationale provided by the restraint reduction strategy.

The author also communicated his project with various ward based clinical nurse managers as he was providing an understanding for the rationale for this project. With the aim that they would encourage the interest of staff nurses working within their clinical area to participate. The author did this by presenting his project to the clinical nurse managers committee advising the various managers that the author aimed to get a group of six to ten nurses together every week in a safe environment and discuss using the “Talk Downs” model on how they could de-escalate potentially aggressive episodes (Bowers, L. 2015). The author placed posters and information on his initiative in common areas that were very accessible to all staff nurses for a week prior to the 1st educational group commencing in order to provide pre education and commitment to the initiative.
Chapter 2 Literature Review

2.1 Introduction.

Fitt, M. H., Walker, A. E., & Leary, H. M. (2009) explain to us that a literature review provides an opportunity for the student to identify, investigate and critically analyse the literature already published that is relevant to their project. The author reviews how the various studies were completed what aspects of the topic have and have not been investigated. This information should inform and develop the author’s initiative, and aid in identifying possible areas to review or possible limitations or challenges to his change initiative (Fitt, M. H., Walker, A. E., & Leary, H. M. 2009).

2.2 Search Strategy.

The author limited his search strategy to only English written academic journals, systemic reviews and some relevant grey literature. He reviewed the literature using four databases Emerald, Medline, Cinnihal and Proquest, he also utilised Google scholar to provide a thorough search of the literature. During the search he noted there was extensive knowledge on aggression in various topics thus he narrowed his search using various search terms such as de-escalation and psychiatric nursing, aggression and psychiatric nursing, educational groups and mental health, de-escalation and aggression, educational groups and aggressive incidents, managing aggressive incident, confidence and aggression, mental health nursing and confidence and Communication. The author intends to review the literature from 2006 highlighting the development of “A Vision For Change: Report of the Expert Group on Mental Health Policy” (Departement of Health and Children, 2006) . As this is the document that encouraged the development of the mental health services
within the Irish health care system. Unfortunately the author noted that following this decision, there is a limited amount of literature regarding an Irish context with most literature focusing on National Health Service in The United Kingdom. Thus the author utilised this literature as the author notes that changes in the mental health services in the United Kingdom are often reflected in the Irish Service. The author also reviewed literature from outside these services mainly in America and Australia. Therefore the author reviewed literature from 2006 to present day mainly from the Irish and British mental health service on the topic of aggression and management of potentially aggressive episodes.

2.3 Review of the Themes.

From the literature gathered using the search strategy the author was able to identify key themes related to challenges in improving the perceived confidence of nurses in de-escalating potentially aggressive situations. Therefore the author aims to using the literature to discuss the following themes:

- Factors that Cause Aggression
- Staff and Service User Communication during Aggressive Episodes.
- Intervention for Improving Staff Approach’s to De-escalating Potentially Aggressive episodes.

Following this the author will discuss how this literature review will impact and develops his change initiative.
Managing aggression is a key aspect for nursing staff especially within the mental health services, unfortunately it is also one of the most difficult challenges faced by staff in their career (Hallett, N., & Dickens, G. L. 2015). Maguire, J., & Ryan, D. (2007) advise this is difficult as there are many different variables to be considered in relation to aggression and developing effective methods in de-escalating aggression. Papadopoulos, C., Ross, J., et al (2012) identify that understanding the causes of aggression plays a fundamental role in developing effective interventions.

### 2.3.1 Factors that Cause Aggression.

The National Collaborating Centre for Mental Health (UK. (2015) identify anticipating and preventing aggression as key aspects of ensuring a safe therapeutic environment. Existing literature recognises the important role that the “cause” and the “effect” of aggression has on nurses highlighting it can often influence decisions regarding how nurses intervene to manage aggression (Dickens, G., Piccirillo, M., & Alderman, N. 2013) (Papadopoulos, C., Ross, J., et al 2012) (Pulsford, D., Crumpton, A., et al 2013). Papadopoulos, C., Ross, J., et al (2012) add to this noting that the causes of aggression can provide situations for nurses to learn and become more skilled at recognising and preventing potential triggers.

Recent trends within the literature highlight internal factors such as the service user’s personality, their mental health or their physical health as factors in aggression on acute ward. However it is argued that these factors are aggravated, through the inter play of other factors such as a lack of privacy, or not been able to leave, and this is a more central factor causing aggression (Papadopoulos, C.,

In understanding the causes of aggression in an acute mental health ward an area of interest within the literature is the environmental factors of aggression. Van Wijk, E., Traut, A., & Julie, H. (2014) discuss some of these factors in their qualitative and phenomenological study highlighting the lack of privacy, the feeling of been overcrowded and lack of activities as reasons for aggression. However the main disadvantage of this study is that it is completed in South Africa thus it may not be transferable to the Irish setting. Although Bowers, L., Whittington, R., N et al (2007) support these findings in their quantitative study into assessing the application of special observations in acute mental health wards in the United Kingdom. Bowers, L., Whittington, R., N et al (2007) highlight that patients often find the lack of privacy and space in acute mental health wards difficult. They highlight that weather the ward is locked or not can cause anxiety for patients which can result in aggression. It has been argued within the literature that environmental factors are not the
primary cause of aggression with other literature highlights the social aspects as having a more prominent role (Bowers, L., Allan, T., et al 2009) (Papadopoulos, C., Ross, J., et al 2012). Cutcliffe, J. R., & Riahi, S. (2013) state that the lack of privacy available for service users has been a factor. However Bowers, L., Whittington, R., et al (2007) advise that providing safe and secure areas such as “snozzle rooms” and comfort rooms have provided for a reduction in aggression instead of just increasing space.

Papadopoulos, C., Ross, J., et al (2012) discuss different antecedents of aggression, mainly highlighting the link of aggression and staff-service user interaction. Bowers, L., Allan, T., Simpson, A., et al (2009) develops this point in their qualitative study into patient aggression and the use of containment methods identifying that service user’s perceived lack of power. The service user may also identify staff been in a position of authority imposing various forms of containment such as detention under mental health law can add tension in their interactions (Bowers, L., Whittington, R., et al 2007). However Bowers, L., Van, M., et al(2012) challenge this within “The City 128 Study” Quantitative study utilising “the Patient-Staff Conflict Checklist”, pointing out that a well organised ward provides for a better environment that can provide service users with more support by planning for conflict situations. One of the main obstacles into studying antecedents of aggression throughout the literature is the difficulty defining aggression. There is different thought’s on what aggression is with some hospitals documenting verbal aggression where others are only document physical aggression, as a result there is an inconsistent reporting of aggressive incidents thus decreasing the validity of the
Within the literature it is clear there are many influencing factors resulting in an aggression. One of the main factors highlighted within the literature is service user and staff interaction, therefore it is clear that how staff communicate to service users is significant in the effective management of an aggressive situations.

### 2.3.2 Staff and Service User Communication during Potentially Aggressive Episodes.

The importance of communication between staff and service user is well documented throughout the literature (Dickens, G., Piccirillo, M., & Alderman, N. 2013), (Bowers, L., Van, M., et al 2012) (Papadopoulos, C., Ross, J., et al 2012) (Bowers, L., Whittington, R., et al 2007). As previously identified staff service user’s interaction is seen as one of the most prominent antecedents in aggression. Consequently this there are many things to consider when interacting with service users during these difficult situations.

One of the items highlighted within the literature is the use of safe space to de-escalate aggression (Hallett, N., & Dickens, G. L. 2015). Hallett, N., & Dickens, G. L. (2015) highlight the importance of providing a private space to de-escalate an aggressive situation within their mixed methodology study into how staff de-escalate aggression. They explain this may be achieved by either encouraging the service
user requiring de-escalation to a more private space or encouraging other service users to move away from the aggressive episode (Hallett, N., & Dickens, G. L. 2015) (McLaughlin, S., Bonner, G., et al 2010). Therefore it is conceivable that by not having a safe area which is comfortable and facilitates a low stimulus space in which staff can have the privacy to adequately communicate, with service users can result in an escalation in aggression (Hallett, N., & Dickens, G. L. 2015). The National Collaborating Centre for Mental Health (UK. (2015) supports these concerns in their guidelines highlighting the importance of ensuring service user dignity and advising that the service user should be separated from others to a quieter area to aid with de escalating the aggressive situation (The National Collaborating Centre for Mental Health (UK. 2015). In addition Hallett, N., & Dickens, G. L. (2015) state that it is not only important to use the right space but also to intervene at the appropriate time. Although they do also highlight that that further investigation is required into this subject. It is important to state that this study despite the robust use of literature, its validity is limited through the use of a qualitative methodology. However it does provide us with various themes related to the successful de-escalation of an aggressive episode (Hallett, N., & Dickens, G. L. 2015)

The role of staff empathy toward the service user in an aggressive situation is underlined as being an important factor in de-escalating an aggressive episode successfully (Price, O., & Baker, J. 2012) (Price, O., Baker, J., et al 2015) (Nau, J., Halfens, R., Needham, I., & Dassen, T. 2010). It is highlighted that the importance of developing a close therapeutic relation with the service user enables nursing staff to gain an understanding with them thus allowing them to interact more effectively with the service user if they are to become aggressive (Stubbs, B., & Dickens, G. 2008).
Bowers, L. (2015) add to this argument, discussing that for a staff member to have an understanding of why a service user is being aggressive enables them to better understand the behaviour and not take it personally. Price, O., & Baker, J. (2012) also discuss this in their review of the literature on de-escalation that staff having an understanding of the service users perspective aids them in communicating more effectively with aggressive service users. Although Bowers, L. (2015) highlights the importance of staff’s self-awareness regarding their communication, they stress that all aspects of how a staff nurse communicate during an aggressive incidents needs to be considered advising a neutral tone and stance, demonstrating that the staff nurse is providing the service user with their undivided attention. However Price, O., & Baker, J. (2012) point out that often staff have difficulty communicating this as a result of the stressful situation. Thus the Confidence of the staff nurse is vital to them being able to communicate effectively and overall de-escalate the aggressive episode effectively (Martin, T., & Daffern, M. 2006).

Martin, T., & Daffern, M. (2006) discuss the importance of staff feeling confident in their quantitative study of staff confidence within the Thomas Embling Hospital in Victoria Australia. They achieve this goal by reviewing the levels of aggression within their own environment and staff confidence in how they view their ability and safety within their work environment (Martin, T., & Daffern, M. 2006). The authors utilise Thackeray’s “Confidence coping with patient aggression instrument” (Thackrey, M. 1987). The authors highlight various proactive strategies that aid in promoting staff confidence, such as the importance of teamwork, an effective environment, an effective response system to difficult situations and a staff profile that had good personal knowledge, experience and skills (Martin, T., & Daffern, M. 2006).

The importance of communication when attempting to de-escalate aggressive episodes is well documented within the literature. Therefore the author can see from the literature that when de-escalating an aggressive episode that there are numerous different factors to consider that may be difficult for staff to implement. In response the development of different models of de-escalation is important to aid the nursing staff in understanding the various challenges and difficulties when attempting to de-escalate aggression. Thus providing strategies to aid for staff to be more confident in communicating with service users who are aggressive.

### 2.3.3 Intervention for Improving Staff Approach's to De-escalating Potentially Aggressive Episodes.

When intervening in an aggressive incident there are numerous different aspects to take into consideration. Price, O., Baker, J., et al (2012) stress that often a nurse’s ability to de-escalate is tied to their personality. However the authors highlight that developing an understanding of various aspects of de-escalating aggression can increase the confidence of staff nurses when interacting with service users in aggressive episodes (Price, O., Baker, J., et al 2012). Therefore there are approaches that have been developed to aid staff in understanding how best to approach de-escalating aggressive episodes.
One of the approaches offered is from Bowers, L. (2014) who develops a model of de-escalating aggression called “Talk Down’s” this model highlights the importance of self-awareness and empathy to de-escalating aggressive episode. Bowers, L. (2014) explain a process for resolving the aggressive episodes through breaking it down into three steps of de-limiting (assessing the safety of the situation), clarify (developing an understanding of why the service user is been aggressive) and resolve (to try and come to a resolution between staff and service user).

Furthermore the authors suggest using small groups to deliver this training using examples from the participants within the groups of situations were de-escalation was successful(L. Bowers, 2014). Davies, B., Griffiths, J., et al (2015) support this initiative stating that if participants feel they have experienced a situation which reflects the nature of focused education, then they will participate more in the training and that they will find more it more valuable.

Nau, J., Dassen, T., Needham, I., et al (2011) adds to this demonstrating in their study adding staff that have been trained in de-escalation techniques are more likely to develop their skills and come up with creative means of de-escalating aggressive episodes. Rippon, T. J. (2000) argue in their systemic review that currently programmes delivered on de-escalation vary greatly in content and duration. However they do support the delivery of this training citing the improvement in staff confidence and knowledge when de-escalating aggressive episodes. Therefore the author can see from the literature the value in delivering de-escalation training that
is thoroughly researched and structured may aid in improving staff confidence (Rippon, T. J. 2000)

2.4 Implication for Project.

This literature review studied potential service user aggression within the mental health services this provided for further rationale and guidance for this organisational change initiative. The author was guided by the literature to three areas, the factor’s causing aggression, staff and service user communication during potentially aggressive episodes and intervention for improving staff approaches to de-escalate potentially aggressive episodes. It is clear that these areas are linked together with staff and service users interaction been identified in the literature as persistent factor in aggression.

Thus by highlighting the importance of communication between the nurse and service user during a potentially aggressive episode the literature guided the author towards developing de-escalation educational groups. Within the literature the author was also able to identify the “Talk downs” model of de-escalation developed by (L. Bowers, 2014) that he would utilise within the educational groups. The literature also provided the author with a means to evaluate the initiative identifying Thackrey’s “Clinical confidence in coping with patient aggression” survey thus allowing the author to evaluate the learning and confidence the nursing staff would gain by participating in the educational groups.
In summary the authors organisational change initiative was guided by the literature that he found, it also aided him in developing and shaping his project. Therefore providing a pathway for the author to identify difficulties that authors have faced in similar projects. Likewise it provided guidance in how to evaluate the project. Also the author was able to identify different instruments utilised within the literature and guidance on how to use these instruments in his project thus increasing the validity of his methodology.

2.5 Conclusion.

The author completed this literature review of aggression and how it is managed with the aim to identify challenges to and improving participant’s confidence in deescalating potential aggressive episodes. This enabled the author to identify three themes: Factors that cause aggression, staff and service user communication during potentially aggressive episodes and interventions for improving staff approach’s to de-escalating potential aggressive episodes. The author was able to reinforce his argument for improving staff nurse confidence and the implementation of the author’s project has developed into a more focused and better evaluated plan. The literature review also demonstrated how other organisations introduced similar change initiatives, thus highlighting potential challenges that the author may experience in his attempts to introduce his organisational change initiative within his clinical area.
Chapter 3-Methodology

3.1 Introduction

The author has worked in the acute mental health setting for the last seven years, consequently he has developed an understanding of the difficulties that nursing staff face when attempting to de-escalate a potentially aggressive episodes. This organisational change initiative concerns itself with attempting to improve nursing staff’s self-perceived confidence in de-escalating potentially aggressive episodes. The author has identified that by introducing education around deescalating a potentially aggressive episodes could increase nursing staff’s self-perceived confidence in their ability during these situations. This could be an intervention that could be developed further as part of an overall restraint reduction strategy.

This project will be completed with the assistance of the nursing staff within the mental health hospital the author works. In this chapter the author intends to review the various methods used to complete this organisational change initiative within his work environment. He will discuss possible change models and discuss his rationale for choosing the HSE change model (Figure 3.1) (The Organization Development and Design Unit. 2008). Then utilising the Health Service Executive (HSE) change model, he will discuss how the various phases aided in developing and shaping his project (The Organization Development and Design Unit. 2008). Subsequently he will describe his actions when guiding his project through these phases and various challenges and resistance he met when implementing this initiative.
3.2 Organizational change

There are various reasons why organizations introduce change some highlight that for organizations to survive and compete they must constantly be changing. Although organizations can introduce changes as a result of many different factors that can be internal to the organization such as staff skill levels or external to the organization such as, guidelines introduced by regulatory bodies (Gerwing, C. 2015). Kotter, J. (1996) advise us that organizational change is seldom a complete failure however it is also seldom completely successful, with most change initiatives been changed and amended as the change process is completed. Gerwing, C. (2015) points out that this highlights the need for organizational change to be planned and considered in a stepped process. Without a stepped process the change agent may attempt to implement the change without first considering or understanding the individual people and factor’s within the organization and thus their efforts to implement change may not develop enough momentum or the change agent can misunderstand the various challenges they face (Ford, J. D., Ford, L. W., & D’Amelio, A. 2008).

3.3 Change Model Selected for Implementing Change Initiative.

There are numerous different change models within the literature designed to aid in guiding change projects. One of the first change models recognised was Kurt Lewin’s three step model of unfreezing, moving and refreezing (Schein, E. H. 1996). This model has been developed and challenged since its conception with various literature often pointing out that as a linear process it does not recognize the complexity of the change process and the role of components such as power and
politics or leadership (Burnes, B. 2004). However Burnes, B. (2004) disagrees with this point arguing that Lewin’s model provides a basis for understanding change and its simplicity provides for more understanding and development of the steps in a change process.

Possibly the most recognisable change model is Kotter’s eight step model for organizational change (Appelbaum, S. H., Zinati, et al 2010). This is quite a complete model Kotter, J. (1996) explains the importance of each step within the model highlighting that the change process takes time and that a considerable amount of effort and time needs to be dedicated to each phase. Kotter, J. (1996) furthermore highlights that maintaining the momentum of a project is vital to ensure effective implementation of organizational change initiatives. However (Pollack, J., & Pollack, R. 2014) contend that Kotter’s linear model does not take into account the dynamic nature of some settings.

Healthcare is of these dynamic settings were multiple different agencies, disciplines and services are attempting to deliver a high standard of care in a safe environment with the service users need at the centre of it (Organization Development and Design Unit. 2008). Thus to successfully implement organizational change one needs a flexible and comprehensive plan that can adapt to the various challenges when implementing change. The Organization Development and Design Unit (2008) have developed the HSE Change Model (Figure 3.1) to aid with organizational change within the healthcare setting. The HSE Change Model is a simple four step model, Initiation, Planning, Implementing and Mainstreaming, although the model is
very much aware that these steps continuously influence each other thus a dynamic approach to change is needed (The Organization Development and Design Unit, 2008). The author identified with the HSE change model as it provided for flexibility and within a clear stepped, planned process. The Author further assess this model and its suitability for this project utilising a Swot analysis to identify its strengths weaknesses (Appendix).

Figure 3.1

3.4 Initiation Stage.

The first phase identified in the HSE model is the initiation phase, this phase is simply about preparing to lead the change. Within this phase the author needed to identify specific’s regarding his change initiative, develop a clear mandate or vision of his change to provide for clear communication to relevant the stakeholders with
the aim of developing commitment to his change initiative (The Organization Development and Design Unit, 2008). To do this effectively the author needed to use the networks he had developed with people within the working environment and identify key opportunities as well as challenges so as he can develop an effective plan for implementing his organizational change initiative (Pollock, J. 2015)

3.4.1 Preparing to lead the change.

To initiate the change initiative effectively the author utilised various assessment tools to identify to identify various factors that impact on this organisational change initiative. As well as the key driving forces for and against his change initiative, the key stakeholders that he could involve in his initiative, and finally the possible strengths and weaknesses opportunities and threats of this initiative.

The author firstly completed an assessment of the culture in his work environment, he did this to assess the readiness within his work environment for the change to occur. Handy, C. (1999) explained that culture is a mixture of the values and beliefs and assumptions that are shared by the people throughout an organisation. They illuminate this further pointing out that depending on the culture then the change agent will have to adapt his approach to suit the culture of the environment (Handy, C. 1999). Pettigrew, A. (1990) describes the concept of culture as “a riddle wrapped in an enigma” reporting that culture is becoming too extensive of a concept to consider when implementing a change. Subsequently Jung, T., Bower, P., & Mannion, R. (2003) adds to this citing that there is over 100 dimensions associated with culture. However the benefits of considering and understanding the culture prior to
attempting to implementing change is well cited within the literature (Robbins T., 2014) (Handy C. 1999).

Been aware of this the author then assessed the culture using the Competing values Framework (Appendix 3 & 4) (Cameron, K. S. 2009). Thus he became aware that the culture most evident in his working environment was a clan culture. Wagner, C., Mannion, R., et al (2014) identify a clan culture as having close relationships and been very traditionalist. Unfortunately they also identify that change initiatives can be difficult to implement due to an emphasis on tradition instead of development (Wagner, C., Mannion, R., et al 2014). This made the author aware that he would have to communicate information regarding his initiative regularly in both formal methods and informal methods to key people. The author also identified within the competing values frameworks that to implement his change the author would need to guide his work environment to a more adhocracy or innovative culture which is demonstrated on the organised culture assessment tool (Appendix 4).

A key part of preparing to lead a change is preparing the environment for the change or creating a sense of urgency (Kotter J., 1996). To do this the author assessed the rationale for his project, completing a force field analysis (Figure 3.2). He did this so he could identify driving forces that could aid him in implementing the change initiative. He then began communicating regarding these driving forces in different ways. For example he ensured a copy of Mental Health Commissions’ “Seclusion and Restraint Reduction Strategy” was placed on each ward (Mental Health Comission, 2013). He also began informally discussing aspects of restraint reduction
with his colleague’s advising them on the importance of developing interventions or methods to aid in reducing the frequency or duration of restraints and encourage more patient centred approaches. Schein, E. H. (1996) advise that there are always resisting forces to counter the forces for change, one of these forces identified by the author would be the clan culture previously discussed. Another resisting force could be in developing interest among some of the nurses and Clinical nurse manager. To overcome these resisting forces the author used the various committee’s like the Restraint Reduction Committee and the Clinical Nurse Manager Committee to communicate the goals, the details of this organizational change initiative and the driving forces supporting this organisational change initiative.

<table>
<thead>
<tr>
<th>Forces FOR Change</th>
<th>Forces AGAINST Change</th>
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<tbody>
<tr>
<td>1 Mental Health Commission</td>
<td>1 Staff Nurse Interest</td>
</tr>
<tr>
<td>2 Restraint Reduction Committee</td>
<td>2 Clan Culture</td>
</tr>
<tr>
<td>3 Service User Centred Care</td>
<td>3 Lack of Time</td>
</tr>
<tr>
<td>4 Developing Staff Nurse Confidence and Skill</td>
<td>4 Conflicting Projects</td>
</tr>
</tbody>
</table>

The impact of the Talk downs model on self-perceived confidence of Nurses for de-escalating potential aggressive episodes.

Figure 3.2
A crucial part of all change initiatives is to identify key people that will aid in the development of your project or people that may pose challenges to the implementation of your change initiative. Therefore the author completed a stakeholder analysis for this reason (Appendix 5). Bryson, J. M., Cunnigham, G. L., & Lokkesmoe, K. J. (2002) explains to us that to identify your stakeholders you need to examine your change initiative thoroughly and identify who it is going to effect. He adds to this stating that by identifying possible stakeholders and involving these people in your change initiative will create a momentum and an enthusiasm for your change initiative (Bryson, J. M., Cunnigham, G. L., & Lokkesmoe, K. J. 2002). While identifying resistors to the initiative will provide you with an opportunity to plan how you can manage them (Al-Haddad, S., Kotnour, T. 2015). Within the authors work environment he identified that the Clinical Nurse Education Co-ordinator as a key stakeholder in this initiative as he was intending to implement a strategy to aid in the reduction of restraints. He also identified that the Clinical Nurse Managers Group and the Clinical Placement Co Coordinators as key stakeholders in this change initiative. As they would be best placed to free staff to attend the educational groups. Furthermore they were well placed to encourage nurses to attend the educational groups thus aiding in overcoming some of the resistance to the initiative.

The author attempted to meet with as many of Clinical nurse manager’s on an individual basis to discuss his change initiative. He did this with the aim of creating a strong coalition to drive the organizational change initiative forward by gaining the support of some of the Clinical nurse managers. The author met the Clinical Nurse Mangers individually as the author felt that he would be better able to gain influence on an individual basis rather than in a group by utilising his personal appeal and
expert knowledge regarding managing aggressive episode. Manning, T. (2012a) emphasise the importance of having expert knowledge and personal appeal to persuade people to support you change initiative, also advising on the importance of ensuring that individuals can relate to the author as well as the change he is trying to implement. The author used the approach advised by Manning, T. (2012a) to appeal both the stakeholders rational understanding but also to use the emotional content of your argument to reinforce your idea (Manning, T. 2012b).

Finally the author also completed a SWOT analysis to gain a more in depth understanding of his initiative (Appendix 7). A SWOT analysis is a simple examination of the strength, weaknesses, opportunities and threats to his project (Reference required). Identifying these various aspects of your change initiative results in clearer and better understanding of your initiative (Auliffe, E. M., & Vaerenbergh, C. Van. 2006). It also allows the change agent to plan their organizational change initiative so as the threats or weaknesses to it can be overcome using the strengths and opportunities identified (Auliffe, E. M., & Vaerenbergh, C. Van. 2006). Through using a SWOT analysis the author was able to identify concerns regarding senior staff been disinterested and not attending the educational groups. This was a concern as he aimed to utilise the experience of senior staff nurses and how they managed potentially aggressive situations to aid in the development of more in-experienced staff nurses. Thus he spoke individually with many experienced nurses to encourage them to attend the educational groups.
Accordingly by completing these assessments and through communication with the various stakeholders, the author was able to develop his initiative. Initially planning to complete a project about debrief with the aim of improving staff confidence, he was able to see that providing educational sessions on de-escalation was probably a better and more sustainable change initiative that would have the same impact. Therefore within this phase with the support of various stakeholders, using various means of assessment and the literature gathered for the literature review, the author was able to develop a clearer vision of how to implement the change initiative and what this change initiative would achieve. While also building enthusiasm and momentum by advising stakeholders about key driving forces for the change. Therefore the author began planning to facilitate educational groups using the “Talk Down” model to aid in improving the self-confidence of the nursing staff in de-escalating aggression.

3.5 Planning

The 2nd phase of the HSE change model is the planning within this phase the author needed to develop the specific detail of his organizational change initiative. He also needed to build on the supports established in the initiation phase by communicating in more detail regarding how he was going to implement the change initiative.

3.5.1 Building Commitment.

Within this phase the author became aware that he needed to develop the networks made in the initiation phase and using these key stakeholders to create a momentum for commencing the change initiative (Kotter, J. P., & Schlesinger, L. A. 1979). Rune,
T., Burnes, B., & Oswick, C. (2012) supported this advising on the importance of clear and continuous communication when leading change to aid in developing a commitment and overcoming resistance to the change. The author continued to communicate to staff nurses both formally and informally taking the opportunity to discuss his change initiative with staff nurses at training that the author leads on the management of aggression and on his lunch breaks with various staff. He did this hoping to increase the readiness and capacity of the nursing staff that would be involved in the change (The Organization Development and Design Unit, 2008). Furthermore he placed “De-escalation” on the agenda of both the Clinical Nurse Managers Committee meeting and the Restraint Reduction Committee meeting where he could advise when the educational groups would begin and continue to reiterate the aim of the educational groups and to seek commitment that nurses would be encouraged to attend the educational groups.

The Clinical Nurse Managers Committee Meeting was a good platform for this as it allowed the author to talk to all the Clinical Nurse Managers who could then disseminate the information regarding the initiative to the various nurses they work with. However the author quickly realised the role that power and politics played within the change initiation as he could see resistance form some Clinical Nurse Managers that would manifest in debates regarding the authors’ project at the clinical nurse managers meeting. Fortunately the author was aware that power is a part of all organised life and to introduce successful change the agent needs to be aware of power and utilise their power appropriately (Fleming, P., & Spicer, A. 2014). Lipman, T. (2000) advised one of the most effective ways of developing influence was by ensuring that others identify with the change and by ensuring that they feel they have
contributed to the change. Thus by meeting with managers individually the author had been able to discuss and amend his project taking the views of other managers on board ensuring that most of the managers identified or felt ownership towards the change initiative. Through this he was able to utilise the commitment he had developed from some of the managers to overcome the resistance from the others.

3.5.2 Determining the Detail of the Change

The detail of the change initiative has continuously evolved as a result of the author’s interactions with various stakeholders in the initiative and his colleague’s in the Action Learning set. These interactions and the literature guided the author to his aim of improving the self-perceived confidence of staff nurses in managing potentially aggressive episodes. The author initially planned to do this using a debrief model but following a review of the literature and discussion with stakeholders. He began to see difficulties in implementing this intervention, as he would have been attempting to implement a change during a very difficult event over a very short time space. Therefore following discussion with his key stakeholders and from the literature he was able to identify educational groups as an intervention that may be more beneficial. Following from this and in discussion with some stakeholders the author was able to identify de-escalation and verbal interventions as an important aspect that an educational group could be based on. Utilising the literature and through discussion with some stakeholders the author was able to identify the “Talk Down” model of de-escalation that is part of the “Safe Wards Strategy” to base the educational Groups on (Bowers, L. 2015).
The author then with the clinical nurse managers at the Clinical Nurse managers Committee meetings asked them to highlight times that would be best for the educational groups to occur, highlighting that the educational group would only last approximately forty minutes. From this meeting it was generally agreed that the weekend was possibly the best time with some of the ward managers requesting that the morning be avoided. Thus the author agreed with the other ward managers to organise the groups for two o clock on Sunday afternoons. Unfortunately he had to review this decision again as a result of not gaining ethics approval in a timely fashion, which is discussed further in the reflective pieces associated with this initiative. Thus the author again discussed and agreed with some of the Clinical nurse managers to deliver the educational group to nursing staff after six o clock on Friday evenings. He also agreed to complete one of the groups on one of the wards directly to the staff working that day. As he realised that he needed to plan for sustaining the momentum by developing a cost effective way to deliver the content to staff. Thus the author planned that following identifying weather there was an improvement in participants self-confidence in deescalating a potential aggressive episodes using the “Talk down” Model, he aimed to attempt to utilise the guide (Appendix 1) and encourage experienced nursing staff to deliver the same content to new nurses within their work environment.

Thus the detail of the change was to implement an educational group based on the “Talk Down” model of de-escalation for a group of eight to ten nurse at times agreed with the Clinical Nurse Manager. The validity of this intervention will be assessed using a basic pre-test/post-test design. The survey used is based on Thackeray’s Survey “Clinical Confidence in Coping with Patient Aggression” (Thackrey, M. 1987).
The author will discuss this further with in the evaluation phase of the HSE change model. However the author also intends to investigate ways of delivering the content throughout the organizational change initiative.

3.5.3 Developing the Implementation Plan.

The plan for implementing the change was quite simple and straightforward, as the author was hopeful that he had communicated and provided the participants and relevant stakeholders with a depth of information prior to the implementation. The author’s main concern was in regard to the attendance of the educational groups. Thus he planned to implement the initiative by speaking with the Clinical Nurse Managers the week prior to commencing the project to reiterate the importance of encouraging staff to attend the educational groups. He also placed posters and information on the change initiative in the staff room of each of the relevant wards (Appendix 8 & 9). He also placed a note on each ward's diary regarding his change initiative for the Sundays that the initiative took place. This also acted in as a method of creating a momentum and a sense of urgency in preparation for the first educational group. On the day of the first educational group the author attempted to contact each ward again to reiterate and encourage staff to again attend the educational group. This was all to ensure clarity about the time and dates of the educational groups and to ensure that all participants were aware prior to attending the educational groups about the study.
3.6 Implementation.

This phase within the HSE Model is about actual implementation of the change initiative and reinforcing the change so as it is sustainable (The Organization Development and Design Unit, 2008). To do this the author needs to provide support and encouragement to participants while work processes and approaches or changing. The author also needs to seek feedback to assess whether the change is having a positive impact on the organization (The Organization Development and Design Unit, 2008).

3.6.1 Implementing the Change.

In this phase the author began implementing and delivering the educational group. On the morning of the first educational group the author contacted the ADON (Assistant Director of Nursing) on duty to remind him of the educational groups taking place. Similarly he attempted rang around to the various wards that would participate in the educational groups to again encourage attendance at the first educational group. At the first educational group there were seven people in attendance. Following this the author needed to review when the next educational group would take place and ensure that this is communicated again to the Clinical Nurse Managers and the nursing staff to ensure a good attendance. After each group the author also evaluated the results and the comments from staff in attendance. Thus using PDSA cycle’s (Appendix 10) after each group the author was able to improve the effectiveness after each of the educational groups.
The author would be attempting to provide support to the nurses that did attend by meeting some of them individually and discussing with them their opinion of the educational group. Also encouraging them to discuss the educational groups with others and to deliver some of the content to less experienced staff nurses. From this the author was able to communicate some of the positive feedback to both the people that he would hope will attend future educational groups and to the stakeholders involved in my project. As Kotter, J. (1996) advises that when implementing change creating small short terms advantages will aid in creating a momentum for your change initiative.

3.6.2 Sustaining Momentum.

Sustaining Momentum is a key part of implementing any change, to do this the author needed to identify the positive effects of his organizational change initiative and to communicate these results effectively and efficiently (The Organization Development and Design Unit, 2008). Moreover the author needed to be aware of any problems that were identified following implementation and address them as quickly as possible with the support of the stakeholders in a satisfactory manner. Consequently by listening to the various issues identified by the various stakeholders and amending the project it provided me an opportunity to give ownership of the initiative to some of the stakeholders.

The author hoped that by identifying and meeting with staff members that had attended the educational group that he could develop a commitment and encourage the implementation of the initiative beyond his involvement. He did this during the
groups noting individuals that expressed an interest in the content and following up with these individuals and providing them with further information and encouragement. The author also met with the managers on the ward following the educational groups to request placing the “Talk down Tips” poster in a prominent place on each ward. Advising them on both the rationale for implementing this change project but also advising on the results that showed an increase in the confidence of individuals attending the educational groups. He did this to ensure that the author’s initiative develops resilience and that the momentum continues to develop. Moreover to ensure that both the clinical nurse managers on the ward and the experienced nursing staff begin to gain ownership of the organizational change initiative.

3.7 Mainstreaming.

The Mainstreaming phase is about ensuring that the new ways of working are integrated into the organisations way of completing their job (The Organization Development and Design Unit, 2008). This is done through two key process firstly by communicating effectively the results of the initiative or as Kotter, J. (1996). advise creating small successes. Secondly by implementing process’s to aid in the sustainability of the project (The Organization Development and Design Unit, 2008). Kelliher, C., Parry, M., et al (2015) tells us that providing methods of support and methods of continuously improving the process and providing more ownership to key stakeholders can improve the sustainability of the change.
3.7.1 Evaluating and Learning.

Understanding whether a change is successful is a difficult process it involves a deep understanding of the change initiative and the aims and objectives of the initiative (Green, J., & South, J. 2006). Thus within this phase the author set about evaluating the educational groups and the how the staff nurses that attended this group viewed them using two different methods. Firstly he utilised a survey “Clinical Confidence in Coping with Service User Aggression” to assess the levels of confidence of staff nurses that attended the Educational Group Thackrey, M. (1987) (Appendix 1). The author then again asked the staff nurses to complete the assessment following the educational group after completing of the group. After this the author had planned to gather people who had attended the educational group for a focus group to discuss if they felt the groups were effective in changing behaviour over a period of time. Correspondingly how they felt the delivery of the groups could be improved, and how it could be delivered in the future.

The author intended to utilise two different approaches as they would provide a greater depth of knowledge as he would be getting both qualitative and quantitative data. The author wished to do this as he was advised in the literature that using a mixed methodology is the most effective way of insuring accuracy but also providing a depth of understanding of the change and the perspectives of other stakeholders. (Ovretveit, J. 1998). However the author was unable to complete a focus group due to time limitations.
3.7.2 Making it the Way we do our Business.

This phase is about ensuring the success of the project and developing the project to ensure that it “becomes the way we do our business” (The Organization Development and Design Unit, 2008). The author attempted to ensure that his initiative developed a sustainability and that it was maintained after his involvement. Key to this was developing a focus group to discuss implementing the initiative on the ward and using the staff at the focus group to deliver the training to in experienced staff. He also requested that the implementation of the “Talk down” models was maintained on both the Clinical Nurse Managers Committee and the Restraint Reduction Committee maintain interest in the initiative. Within the Clinical Nurse Managers Committee he requested that the poster showing the “Talk Down” tips (Appendix 7) be placed on each ward to also sustain momentum and to encourage experienced staff to discuss de-escalation with less experienced staff.
Chapter 4- Evaluation.

4.1 Introduction.

Evaluation is a key aspect of any initiative as the author must be able to assess the validity and the reliability of the change initiative to understand if it is effective (Ovreveit J., 1998). Green, J., & South, J. (2006) adds to this informing us that evaluation can be a complicated process and it requires careful consideration throughout the initiative. Ovreveit J. (1998) continues highlighting that the aims and objectives of an organizational change initiative need to be carefully linked to how they are going to be evaluated. McNamara, G., Joyce, P., & O’Hara, J. (2010) inform us that a good evaluation plan should provide for an efficient use of time and resources. However, effective evaluation should also consider that a program may also have implications outside the local environment of where the change is being implemented (McNamara, G., Joyce, P., & O’Hara, J. 2010).

Thus the author began considering how his initiative would be evaluated from the very beginning. The author strived to ensure that his initiative was well researched and developed using the information discovered throughout the literature review to inform the evaluation process. Through the author’s literature review he was able refine his change initiative and identify what the aims and objectives should be and identify how best to evaluate them. Throughout the change initiative the author reviewed these constantly to ensure efficacy, reliability and validity.
4.2 Evaluation Models.

To evaluate an initiative effectively Ovreveit J. (2003) suggests using a model to ensure that the evaluation of the change is reliable and takes into consideration all the variables within the process. Choosing the correct model requires careful consideration of the initiative and its overall aims. As each evaluation model has a different focus and is designed for evaluating different processes (Ovreveit J., 2003).

Generally methods of evaluation are divided into different approaches, a formative based approach which focuses on the processes and various other factors involved in a change, and a summative based approach which focuses on the outcomes and the evaluation of initiatives.

In Donebedian’s model to evaluate change it highlights the importance of considering the Structure, Process and Outcome of the change (Bowling, A. 2009). As the structure is the organizational environment already in place, the process is how the author plans to implement the change and finally outcome is the impact of the overall change (Bowling, A. 2009). This is a simple model designed to clearly evaluate a change initiative in a simple straightforward way (Bowling, A. 2009).

However due to his narrow definition of the outcome of a change initiative, it does not take into consideration the sustainability of the process’s put in place. Although its simple form does allow it to incorporate both systems based and objective based models (A. Zinovieff, M., & Rotem, A. 2008). However, considering the author had identified a goal of evaluating the effectiveness of the Talk down De-escalation Model he felt it more appropriate to concentrate on summative based model.
Thus the author looked to Kirkpatrick’s Model (Figure 4.1) to evaluate the educational groups as it was designed to evaluate different educational interventions (Kirkpatrick, D. L. 1996). It evaluates the outcome of using four levels Reaction, Learning, Behaviour and Results (A. Zinovieff, M., & Rotem, A. 2008). Reaction is the initial reaction of the participants at the training, Learning is simply what the participants learned during the group, Behaviour is how the training has influenced the behaviour of the participants and finally Results is the overall result’s to the change initiative that have occurred within the organization taking into consideration possible implications outside of the local environment (Kirkpatrick, D. L. 1996). Some authors have been critical of this model’s approach to evaluating training, questioning the assumptions of the increasing importance in the four levels as they ascend (Bates, R. 2004). Bates, R. (2004) also highlights that this model is incomplete; highlighting that it has even been modified to include a fifth process that would measure the return on investment of any change. Despite some of the criticisms of this model, the author concluded that each of the four levels in Kirkpatrick’s model provide a clear and complete approach to effectively evaluate the results of his change initiative within his work environment.

Figure 4.1
Aim

The aim of this study is to investigate whether implementing educational groups using the “Talk Downs” model of de-escalation, will positively influence self-perceived confidence of nurses in de-escalating potentially aggressive episodes.

Objectives:

- Facilitate six educational sessions over a five week period for ward based nurses beginning on the 6th of March 2016.
- Survey the participant’s self-perceived confidence in de-escalating potentially aggressive episodes prior to and after each educational group.
- Establish over the six educational sessions if the content of the module is sufficient in this format to positively influence the self-perceived confidence of staff nurses in de-escalating potentially aggressive episodes.

The author had a very simple aim of evaluating the “Talk Downs” model of de-escalation. To do this he needed to accomplish his objectives of first facilitating six of the educational groups, secondly to survey the participants prior to and after they have attended the educational group and finally to establish if the format used in the educational groups was sufficient to influence the self-perceived confidence of the nurses. Thus the author considered how he could incorporate these aims and objectives and ensure that they were effectively measured.
4.3 Outcome Review.

4.3.1 Reaction

Reaction is the first level and its main concern is how people feel in regard to the training or in this case the educational group (McNamara, G., Joyce, P., & O’Hara, J. 2010). We are advised that this is the easiest and clearest level to measure however it does not tell us anything in regard to learning gained through the intervention (Kirkpatrick, D. L. 1996). Thus the author evaluated this by reviewing the attendance at the educational groups that followed and by speaking informally with people that attended.

Unfortunately the author was only able to complete five educational groups due to time limitations, thus he did not achieve his objective of facilitating six of the educational groups. The overall attendance of the group was thirty four nurses spread over the five educational groups. This was a random sample of 34 nurses of varying experience and skills who work within the organization that the author works. Using this sample the author was able to identify that the reaction to the groups was quite positive as a result of the attendance and informal feedback from staff that attended. As can be seen on Graph 4.1 initially the attendance dropped with the second and third group only having five staff in attendance. The fourth and fifth educational group had attendance of ten and seven participants respectively.
The author also informally discussed with various nurses that attended the group, how to improve the educational group. Thus the author acquired a good understanding of the samples initial reaction to the group, with many identifying the benefits of a facilitated educational group as opposed to a teaching led educational lecture. Many of the participants reported that the facilitator encouraging engagement from all participants was most beneficial. They also identified that the length of the groups (thirty – forty minutes) provided for a good method of promoting development of these new skills. The author evaluated participants reactions and attempted to improve the groups using PDSA cycles (Appendix 10) to enhance the learning developed in the next educational groups. However as previously stated despite the good attendance and some positive feedback this did not evaluate if effective learning had been achieved (Kirkpatrick, D. L. 1996).
4.3.2 Learning

To assess the effectiveness of any change initiative their needs to be an effective method of evaluation in place to understand if any change actually occurs (Bowling, A. 2009). To do this the author utilised a pre and post survey method and after contrasting the results of both surveys the author was able to assess the impact on self-confidence of the various participants that attended the educational Group. To do this the author utilised a survey based on the Thackrey’s “Clinical Confidence in Coping with Patients Aggression” (Appendix 1).

This Survey was developed in 1987 to review the effectiveness of training in managing patient aggression (Thackrey, M. 1987). Unfortunately some of the questions involved in the original study were not suitable for my current study as the author’s study did not involve any physical interventions. Thus the author utilised a modified version of this survey that was used by Martin, T., & Daffern, M. (2006) to assess the clinical confidence of staff within the environment of the Thomas Embling Hospital (Appendix 1). This was a simple seven question survey, using the mean evaluation of various groups to assess the self-confidence of staff in regard to how safe they felt within the Thomas Embling Hospital (Martin, T., & Daffern, M. 2006). Thus the author utilised this survey and method to evaluate his intervention. The author did this by requesting that the participants complete a survey prior to the educational groups and after the educational groups and then comparing both results and assessing if there was a significant difference in the result.
Consequently the author assessed the levels of confidence using this method. The author also reviewed the responses using two different experience levels as a variable to compare the results against each other. The author reviewed participants that had qualified under two years or were 4th year intern’s on their rostered placement against all the staff that were qualified over two years. The author did this as a result of nursing staff reporting within the initial phase of this initiative that nursing staff experience was an important factor in a nurse’s ability to successfully de-escalate a potential aggressive situation.

However in the initial assessment as per the identified objectives the author first clarified the levels of confidence that participants had in deescalating potential aggressive situations. As can be seen in graph 4.2 the mean level of confidence prior this initiative was 69%. Following completing the educational group on the “Talk Downs” de-escalation model it was evident that the participants did gain some confidence. As can be seen in Graph 4.2, there was an overall increase in participant’s perceived confidence by 7%. As a result this demonstrates that the content of the educational group is effective in increasing the perceived confidence of staff nurses who attended. However this does not highlight to us if the learning during this initiative is sustainable or if it will influence the future behaviour of the participants.
It is also evident from Graph 4.3 that the staff's level of experience did play a role in perceived confidence. Staff with more than two years' experience reported being marginally more confident with a 7% difference between the responses of both groups. However contrary to expected results the more experienced participants seemed to find more value from the Educational groups than the less experienced participants. With the inexperienced staff reporting that they only gained 4% more confidence were as the more experienced staff reported a gain of 8%. This information is important for the development of the author's initiative as it shows that it would be an error to concentrate on less experienced nursing staff.
4.3.3 Behaviour

Behaviour is the most difficult level of an initiative to assess. However it is also one of the most important, as for an initiative to be truly effective then it needs to change and influence the behaviour of its participants (Bates, R. 2004). This should be a key aim for any initiative as it is key to the sustainability of the initiative (Bowling, A. 2009).

The author assessed changes in behaviour through informal conversation. The author had also hoped to complete a focus group however would he would have need to seek permission from the relevant ethics committee which unfortunately due to time constraints was not possible. The author hoped to complete a focus group to develop an understanding if participants felt comfortable and able to deliver the
content taught at the educational groups to inexperienced staff on the wards they work on. Thus the author would also have been able to discuss with the participants in attendance the importance of behavioural change in sustaining the initiative.

However the author was able to assess was able the value that people placed on the changes developed in his initiative through informal individual feedback. The author received positive feedback with many reporting an increase in conversation between experienced staff and more inexperienced staff regarding de-escalation of a potential aggressive episode. They also reported that there had been an increase in staff discussing how they approach potentially aggressive episodes.

4.3.4 Results

All initiatives have far reaching impacts beyond the change agent's initial plans, these are often difficult to evaluate as these impacts need to be evaluated over a considerable amount of time (Kirkpatrick, D. L. 1996). Thus the author needs to identify if he has improved the organization within where he works. The author needs to take into consideration the organization wide impact of his initiative (Parry, G. J., Carson-Stevens, A., et al 2013). This is a very complicated process as to do this the author first needs to assess that his initiative was successful and then evaluate its impact on the wider organisation (Kirkpatrick, D. L. 1996).

The author aims that by implementing this initiative that it would aid in reducing the level of physical interventions required in managing potentially aggressive situations,
as staff nurses would feel more confident intervening on a psychological level during a potentially aggressive episode. As a result of the decrease in the number of restraints and taking into consideration the literature the author would hope that there would be a decrease in absenteeism and an increase in staff morale (Bowers, L., Whittington, R., Nolan, P., et al 2007). The author would hope to review this by holding a focus group with key stakeholders involved in the initiative and through feedback gained from the various committee’s that aided in implementing this initiative.

### 4.4 Conclusion

The author unfortunately did not achieve his objective of completing 6 educational groups. The objective of assessing the participants that did attend was successful and it did demonstrate that the approach for delivering the educational groups was sufficient enough to influence the self-perceived confidence of the participants in deescalating potential aggressive situations.

To assess this further the author used a quantitative method to evaluate his initiative were the comparative results from the survey indicated that participants showed an increase in self-confidence as a result of the author’s initiative. Thus the overall aim was successful; unfortunately there is a need for more formal methods to evaluate the overall impact and the behavioural change that resulted from this initiative. The author sees this as a key next step in developing the sustainability of his initiative. By utilising the network built within this initiative the author hopes to implement the
delivery of the “Talk downs” educational group by senior staff to less experienced staff on the ward.
5.0 Discussion and Conclusions.

5.1 Introduction.

De-escalation of potential aggressive episodes is a very difficult process. From previous discussions highlighted in this initiative it is clear that attempts to aid in developing the self-confidence of staff nurses in deescalating potential aggressive episodes is an equally difficult and complicated process.

The author's vision for this organisational change initiative was to develop a method to improve nursing staffs’ confidence in de-escalating potential aggressive situations. The first part of his plan was to review the literature and working with his stakeholders to develop a method to achieve this vision. From the literature he identified a number of things to aid in achieving this vision. Thus the author refined his vision to incorporate the “Talk downs” model and methods of evaluation discovered in the literature. Following this he organised educational groups and developing a plan to evaluate and ensure the effectiveness of the initiative.

Within this chapter the author hope to review his complete organisational change initiative. He will discuss and reflect different challenges he faced and different accomplishments within this initiative. The author hopes to highlight the different strengths and limitations of this initiative and develop recommendations for future studies. Finally the author hopes to discuss how he hopes this organisational change initiative will develop and what he hopes will be its overall impact.
5.2 Discussion.

Throughout the development and implementation of this initiative to improve staff confidence in deescalating potential aggression the author faced many challenges that helped shape and progress various aspect of his initiative. This can be seen quite clearly within the reflective pieces accompanying this dissertation.

Initially the author had planned to utilise debrief as a method of staff learning from their experience as advised by the Mental Health Commission in their restraint reduction strategy (Mental Health Commission, 2013). However following discussing with colleagues at the action learning set and on reviewing the literature the author began to see the challenges and difficulties to using debrief in an effective and efficient way as his change, which is studied more in the reflective piece accompanying this initiative. He began investigating factors that cause aggression and then reviewing how best to improve staff responses to potential aggression. From the literature review and in interaction with stakeholders aiding him, the author identified service users and nursing staff interactions during a potential aggressive episode as a key concern. Thus he focused in on this aspect and developed his organisational change initiative around staff and service users’ interaction during potential aggressive episodes.

By focusing in on the service user and staff nurses interaction the author was able to identify the “Talk Downs Model” of de-escalation. This was developed by Len Bowers and was one aspect of the safe ward strategy developed within the NHS with the overall aim of restraint reduction (Bowers, L. 2014). However the author was very
much aware that the overall strategy had demonstrated positive results this single aspect had not been investigated independently. Consequently this initiative’s aim was to investigate whether implementing educational groups using the “Talk Down”, model of de-escalation, would positively influence self-perceived confidence of nurses in de-escalating potentially aggressive episodes. To do this the author needed to plan, organise and implement six educational groups. Thus the author needed to work with many different stakeholders as seen in the Stakeholder analysis (Appendix 5). He needed to communicate effectively both on an individual level and within various different committee’s to develop interest for the initiative and communicate the potential positive impact of this initiative to the various stakeholders.

Unfortunately this proved challenging as the author had difficulties gaining ethics approval. Therefore he was unable to give a definitive start date of the educational groups. This posed many difficulties as can be seen in the accompanying reflective pieces. For example it resulted this initiative been very time limited but also resulted in a slowing of the momentum that the author’s initiative had developed by interacting with the various stakeholders. Therefore the author realises that he needed to be more definitive on his project at a much earlier date, so as to gain ethics approval much sooner to maintain the momentum of his initiative.

On gaining ethical approval the author was able to commence the educational groups. However due to time limitations he was only able to implement five groups instead of the planned six groups. Nevertheless a good level of attendance was
achieved with thirty four nurses of varying experience attending the groups. And as previously discussed in chapter four there was a seven percent overall increase in confidence in deescalating aggression identified. Throughout facilitating the groups the author was continuously attempting to improve the groups using PDSA cycle’s (Appendix10) based on informal feedback from the participants. With many of the participants reporting that they enjoyed the relaxed approach to the educational groups and value placed on their own experience. As a result the author reviewed methods of increasing the involvement of the participants in the groups. The author felt this was important as he hoped that staff would also share experience and develop methods of de-escalating potentially aggressive episodes outside of the educational groups. Consequently develop a culture within the author’s work place where there is more value on nursing staff’s ability to interact with service users during potentially aggressive episodes.

5.3 Impact of Initiative.

This study had an impact in the author’s work environment in many different ways some of which were unexpected to the author. The author reviewed the impact this initiative had on the key stakeholders involved. Similarly he reviewed how it imparted on the practice of how the organization delivered care to care our service users and how training is delivered to aid in the development of our nursing staff.
5.3.1 Stakeholders.

Staff Nurses.

The authors overall aim from the beginning of this initiative was to positively impact on staff nurses self-confidence in deescalating potentially aggressive episodes. By evaluating the “Talk Downs” model the author has been able to identify a seven percent increase in staff nurses self-confidence when faced with a potentially aggressive situations. Unfortunately the author has not been able to identify the long term impacts of this initiative. However he would be hopeful that by developing a framework for deescalating potential aggressive episodes and facilitating these educational sessions that this will encourage staff to share their experiences in deescalating aggression. Moreover the author hopes to further develop this initiative encouraging nursing staff with experience in deescalating potentially aggressive episodes to support their colleagues to further develop and understand the various methods factors in deescalating potentially aggressive episodes.

Thus the impact of this project was that the thirty four nurses that attended the educational groups did gain a seven percent increase in their perceived confidence in deescalating aggression. However the author also hopes that there will be a development on a cultural level within his work environment with staff becoming more aware of their role in the development of their colleague’s confidence in deescalating potentially aggressive episodes.
Clinical Nurse Managers.

To implement this initiative the author needed to work quite closely with various clinical nurse managers. To do this he needed to advise them on how he thought his initiative would positively impact on their experience as clinical nurse managers. Advising them that the aim of this initiative was to increase staff confidence in deescalating potentially aggressive episodes, consequently encourage staff to act more independently with respect to the policies within their work environment, but also advising staff of their responsibility in encouraging the development of their colleagues. Therefore the author hoped that the impact of his initiative will guide the culture while encouraging nursing staff to work more independently which should result in less dependence on the relevant Clinical Nurse Manager.

5.3.2 Practice.

The author is hopeful that this organisational change will feed into the development of a more comprehensive change regarding the introduction of a restraint reduction strategy. As by accomplishing the author’s aim of increasing nursing staff’s self-confidence to deescalate potentially aggressive episodes more effectively, he is hopeful that this will aid in reducing the levels of restraint required within his work environment. Therefore he would hope that this organisational change initiative would be an important part of a future restraint reduction strategy. The author would similarly hope that this project will aid in building commitment and creating a sense of urgency towards introducing a restraint reduction strategy (The Organization Development and Design Unit, 2008).
5.4 Strengths of Initiative.

The strength of this project lay very much in the enthusiasm and wiliness of the author's fellow staff nurses and clinical nurse managers to develop and learn from each other. Without the support and advice of the author's colleagues this initiative would not have been possible. He was totally dependent on the staff nurses and the clinical nurse managers developing a commitment to his vision of attempting to improve staff nurse's perceived confidence in deescalating potential aggressive episodes. While also seeing value in how he was attempting to implement these changes. This was demonstrated by having a good attendance at the five educational groups.

The author realises that his initiative was very focused in on a simple idea of using an educational group on deescalating potentially aggressive situations. This was a strength as explained by Kotter, J. (1996) that a simple plan that is easily communicated will generally be more successful. Manning T., (2012a) advise on the importance that when attempting to communicate changes and to gain interest in the initiative that ensuring that only important information is communicated and that participants can easily follow the plan for any change initiative.

5.6 Limitations of Study.

However the author is very much aware that this initiative definitely was not without its limitations. One of these challenges was in attempting to measure the concept of participant’s self-perceived confidence. It is something that is quite difficult to quantify, as there are many different variables that can influence how an individual
perceives their confidence. The method used in this initiative was to measure using a survey “Clinical Confidence in coping with patient aggression” and to assess using this survey the initial self-perceived confidence prior to the educational group of the participants and then to re-assess their self-perceived confidence after the groups (Thackrey, M. 1987). The author was aware that to assess the effectiveness of this assessment that he should re-assess again after a period of time to ensure that the learning achieved was sustained (Malterud, K. 2001). This was difficult to complete due to the time limitations of this initiation.

Time was a key concern throughout this initiative as to evaluate a concept like a person self-perceived confidence involves many variables. The author aimed to attempt to evaluate the project using both qualitative and quantitative methodology to take account of these variables. However the author was unable to complete this as he had not considered this when applying for his ethics approval. Green, J., & South, J. (2006) highlight that using a mixed methodology approach ensures a more complete evaluation of interventions as quantitative methodology provides for reliability and qualitative approach takes all the different variables into consideration by providing for a subjective approach for each participant.

The author’s lack of experience is clear to be seen from these various decisions, hence he realises that he should have used the support networks he already had in place prior to beginning this initiative. If he had used this support he would possibly have gained more direction using the guidance of his more experienced colleagues (Ibarra, H., & Hunter, M. 2007). This could have helped the author to be more
organised and overcome challenges earlier in the processes of implementing his initiative limiting their negative impact. This is especially relevant in relation to the author gaining ethics approval for his initiative.

The author felt that he communicated his project effectively however from the experience of implementing the change he feels that utilising a focus group instead of meeting some stakeholders individually would possible have been a more effective method of communicating his initiative. As often focus groups provide for the development of a stronger coalition as it provides for the development of commitment and support and gives the coalition more ownership on the project. Bowling, A. (2009). A Focus Groups would also provide for the participants to be more forthright in their opinions and through discussion could aided the author in developing clearer insights to various challenges when implementing organisational change initiative (Barbour, R. S. 2005)

5.7 Recommendations for Future Studies.

The author has recommendation's to aid for future evaluations of the “Talk down” Model. He would advise that in the initiation phase, for the change agent to identify key stakeholder and use a focus group to develop a strong coalition to aid in driving the change forward. By using this coalition the author could then create a sense of urgency to develop momentum towards the change and identify challenges and difficulties that could obstruct the development of the change initiative. Furthermore a focus group would of aided in planning how the organizational change would be effectively planned, communicated, implemented and evaluated taking many
different perspectives into consideration (Barbour, R. S. 2005). The author would also advise that the initiative be completed over a longer period of time so as behaviour or social changes resulting from the initiative can be evaluated. Also that the sustainability of the project can be further developed and planned following the evaluation.

5.8 Project Development.

The author has begun developing his project further after identifying the positive impact of utilising the “Talk down” model to increase self-confidence of nursing staff in de-escalating potential aggressive episodes. With the support of various stakeholders he has begun planning to deliver the “Talk down” model in a more efficient manner. Therefore the author has spoken with the Clinical Nurse Manager now working in the acute ward within his work environment and they have agreed to place the “Talk Down” poster (Appendix7) in a prominent place that is visible for all nursing staff on the ward. The author intends to meet with the participants identified during the educational groups based on this ward and encourage them to discuss and explain the “Talk down” models with individuals who may be unfamiliar in deescalating potential aggressive episodes. As a result the author would be hopeful that in time with some support and encouragement that experienced nurses would feel that explaining how to use “Talk down” model to de-escalate potential aggressive episodes would become a key part of the culture within his work environment.
5.9 Final Conclusion.

This organisational change project involved the evaluation of the “Talk down” model on the self-confidence of nursing staff to deescalate potential aggression. It was a very simple design of requesting the participants to complete a survey before facilitating an educational group to them on the “Talk down” model of de-escalation, and following this the author asked again them to complete the survey, contrasting the results to understand weather there was positive impact on their perceived self-confidence. The evaluation showed that there was a 7% increase in the nursing staff’s confidence.

Throughout the initiative the author faced many challenges and difficulties. He realises at times the decisions he made when leading this organisational change initiative could have been better. However individual feedback from participant and stakeholders has been positive for this organisational change initiative. Thus the author intends to ensure that this increase in confidence is further developed and ensure that evaluation of the “talk down” is the first step in implementing it in a more efficient and effective way within his work environment. Moreover possibly the first step to introducing an overall restraint reduction strategy within his work environment.
References


Royal College of Surgeons (2015)


Appendices

Appendix 1.

Guidance for “talk down” training

Guidance for Talk Down training

Your ward manager has chosen you to be a champion for this intervention, as they recognise that you are skilled in de-escalation.

The Talk Down poster displays some techniques to help people feel calmer, and more in control, during times when they are very agitated, angry or upset. Practising these techniques can help us to avoid the use of containment measures such as restraint or IM meds.

The length of the training is up to you, it could be very simple and take just 15-20 minutes to talk through with each person, or you may have some other ideas about how to do it.

1. Explain the aim of the poster, giving examples of the kinds of situations where these techniques can be employed.

2. Briefly summarise the poster:

   Example: This poster illustrates a three stage process of de-escalation, which should be implemented in a controlled way, with respect and empathy for the patient.

3. Talk through the central part of the poster. Spend most of your time on this bit; it is the most important part and is comprised of three stages:

   - Delimit: Gain control over the situation.
   - Clarify: Work out what the problem is.
   - Resolve: Find a solution to the problem

Talk the person through each step, and cover each point, explaining the reasons behind the techniques:

   Example (Delimit): People don’t like giving way in front of their peers, so moving to a more private area will mean you can talk without someone feeling they have to lose face.

   Example (Clarify): Use the person’s name. This immediately establishes an interpersonal relationship.

When administering the training you might want to talk about times when you have successfully used these techniques, or give examples of how not to do things:

   Example (Clarify): Ask “what’s going on Leo? You seem very upset and angry?” rather than “what’s all this about? Are you complaining about the food again? We’ve already told you there is nothing we can do about it?”

It might also help to ask questions during the training:

   Example (Delimit): Why do you think it might help to sit down with someone, rather than talking whilst standing?

4. Spend about five minutes discussing the sections ‘Respect and empathy’ and ‘Control yourself’. Without these things, the process of de-escalation will not work. You do not have to cover each point here, instead pick a few that you think are the most important. For more information on how to ‘control yourself’ refer to the Safewards handbook (p65–74).

5. At the end of training give a summary, and answer any questions.
Appendix 2.

Confidence in Managing Service user Aggression.

Length of Practice as a registered Psychiatric Nurse: _____ Years _____ Months.
Male _____. Female_____.

Please answer the following questions, indicate your response by circling your response by circling the appropriate number.

1. How confident are you in your work with hostile an aggressive service users?
   1. 2. 3. 4. 5. 6. 7. Confident. Not Confident.

2. How safe do you feel around aggressive and aggressive service users?
   1. 2. 3. 4. 5. 6. 7. Safe. Very Safe.

3. How able are you to de-escalate an aggressive service user?
   1. 2. 3. 4. 5. 6. 7. Not at all. Very Able.

4. How able are you to contribute to the restraint of an aggressive service user?
   1. 2. 3. 4. 5. 6. 7. Not at all. Very Able.

5. How able are you to maintain your own safety in the presence of an aggressive service user?
   1. 2. 3. 4. 5. 6. 7. Not at all. Very Able.

6. How confident are you in the ability of your colleagues’ ability to maintain your safety and manage an aggressive service users?
   1. 2. 3. 4. 5. 6. 7. Confident. Not Confident.
7. How safe do you feel the environment in St Patricks Mental Health Services is?  
   1. 2. 3. 4. 5. 6. 7.  

8. Identify factors that positively or negatively impact on your confidence in managing aggressive incidents.  
   ____________________________________________________  
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9. Identify different methods of de-escalating aggressive incidents.  
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Appendix 3.

Competing Value Framework: Organizational Culture Assessment Instrument (OCAI).

Instructions for completing the Organizational Culture Assessment Instrument (OCAI).

Competing Values Framework
6 key factors assessed in Organizational Culture Assessment

The purpose of the OCAI is to assess six key dimensions of organizational culture. In completing the instrument, you will be providing a picture of how your organization operates and the values that characterize it. No right or wrong answers exist for these questions, just as there is no right or wrong culture. Every organization will most likely produce a different set of responses. Therefore, be as accurate as you can in responding to the questions so that your resulting cultural diagnosis will be as precise as possible.

You are asked to rate your organization in the questions. To determine which organization to rate, you will want to consider the organization that is managed by your boss, the strategic business unit to which you belong, or the organizational unit in which you are a member that has clearly identifiable boundaries. Because the instrument is most helpful for determining ways to change the culture, you’ll want to focus on the cultural unit that is the target for change.

The OCAI consists of six questions. Each question has four alternatives. Divide 100 points among these four alternatives depending on the extent to which each alternative is similar to your own organization. Give a higher number of points to the alternative that is most similar to your organization. For example, in question one, if you think alternative A is very similar to your organization, alternative B and C are somewhat similar, and alternative D is hardly similar at all, you might give 55 points to A, 20 points to B and C, and five points to D. Just be sure your total equals 100 points for each question.

Note, that the first pass through the six questions is labelled “Now”. This refers to the culture, as it exists today. After you complete the “Now”, you will find the questions repeated under a heading of “Preferred”. Your answers to these questions should be based on how you would like the organization to look five years from now.
## The Organizational Culture Assessment Instrument

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Scoring

Scoring the OCAI is very easy. It requires simple arithmetic calculations. The first step is to add together all A responses in the Now column and divide by six. That is, compute an average score for the A alternatives in the Now column. You may use the worksheet on the next page to arrive at these averages. Do this for all of the questions, A, B, C, and D. Once you have done this, transfer your answers to this page in the boxes provided below.

Fill in your answers here from the previous page

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An Example of How Culture Ratings Might Appear

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SUMMARY ASSESSMENT DATA

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Scores

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Appendix 4.

Organised Cultural Assessment Tool.

Results from my Workspace
### Appendix 5.

#### Stake Holder Analysis.

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| Low Interest / Low Power | - Assistant Directors of Nursing.  
- Chairman of CNM Committee.  
- Clinical Nurse Managers.  
- Staff Nurses                                                                 |

| Low Interest / High Power | - Staff Nurses.  
- Clinical Nurse Managers.  
- Director of Nursing. |
Appendix 6.

Swot Analysis of Project.

**Strengths**
- Enthusiastic young staff willing to learn.
- Hospital drive for restraint reduction.
- Mental Health Commission drive for restraint reduction.

**Weaknesses**
- Inexperience staff adapting to new environment requiring guidance from more experienced staff.
- Clan orientated culture requiring more innovation.
- Disinterest in the educational groups from experienced staff.

**Opportunities**
- Project should improve safety and increase staff perceived confidence.
- Develop a more innovative culture within work environment.
- Increase staff nurses autonomy.
- Develop a culture that is more service user centred and offer staff training in relation to alternatives to restraint.

**Threats**
- Time challenges
- Difficulty getting clear evaluation of project
- Opposition to change
- Staff concern of been questioned regarding decisions related to aggressive incidents
Appendix 8.

How to De-Escalate Aggression?

An Educational Group on De-escalating Aggressive Incidents Using the “Talk Downs Model” for Nurses.

Sunday @ 2pm in the Nurse Recreation Area All Nurses Welcome.

Participants in this group will be asked to complete a questionnaire prior to and following educational group. The questionnaire is based on Thackrey’s “Clinical Confidence in Managing Patient Aggression”
Appendix 9.

Title of Research: An evaluation of the impact of the Talk downs model on self-perceived confidence of Nurses for de-escalating potential aggressive episodes.

Information Sheets for Participant.

Dear Participant,

You are invited to participate in a Study to investigate if the “Talk downs” model from the “safe ward” strategy for restraint reduction would positively impact on your confidence to de-escalate potential aggressive episodes. I would invite you to participate in educational groups utilizing the “talk down” model so we can develop and improve our ability to de-escalate aggressive situations.

Before you agree to take part let me explain what is involved in the educational groups. These groups will be approx. 6-10 nurses and they will take place at 2 o clock on Sunday afternoons. In these groups we will utilize the “talk downs tips” poster which brings us through a simple method of de-escalating an aggressive situation. During this the author hopes to utilize the experience of the nurses in the room to discuss situations where we have successfully de-escalated situations. Hopefully from this we can learn and improve how we interact with service users during potentially aggressive incidents.

The Investigator will also ask you to complete a simple survey as part of this study to assess how everyone perceives their confidence prior to the educational group and after the educational group. This is a simple survey based on Thackrey’s “Clinical Confidence in Coping with Patient Aggression Instrument”. From these surveys the author aims is to assess whether the educational groups on “talk downs” does positively impact on nurses own perception of their confidence in de-escalating
aggressive situations. The surveys will be completely anonymous with the author only wishing to identify the questionnaires from before and after the educational group.

Discussing the management of aggressive situations may be difficult for some people, especially in front of a group. Therefore the author would encourage all nurse considering participating in the group that are concerned to make contact with him. They can then discuss the groups further before deciding whether to attend. This study has been reviewed and approved by the St Patrick’s Mental Health Services Research Ethics Committee.

Please do not hesitate to contact me if you require further information.

Thank you in anticipation.

Yours sincerely

Francis Mc Carron

Mobile Phone Number: (087)7962345

Email Address: Fmccarron@stpatsmail.com
Appendix 10
PDSA Cycle’s Related to Educational Groups.

1st Educational Group

Plan.

The 1st educational group took place in the nurse recreational area at half two on a Sunday afternoon. I had wrote in the diary of each ward and had spoken to each ward manager and had planned to ring each ward on that morning.

Do.

I had planned to ring each ward however I had only got through to two of the wards as I only started ringing them at 1 o clock.

Study.

On reflection I realised that ringing a ward at 1 o clock was too late as staff had already agreed on what duties each of them would do. Also I was ringing the ward while staff were trying to ensure that service users were getting their dinner, thus I did not get through to 7 of the wards. Two of the wards had no nursing staff in attendance and I had been unable to get in contact with those wards on the morning of the group.

Act.

Following this I decided I would ring earlier in the morning when the ward would be quieter. Thus I decided I would contact all the wards at 11 o clock.
2nd Educational Group

Plan.

The 2nd educational group it was agreed would take place on a ward to aid in assessing the validity of delivering the educational group on a ward setting or off the ward. Thus the author visited the ward to deliver the group. The author planned the group for 2 o clock on a Wednesday afternoon.

Do.

The group was delivered on a ward setting unfortunately the author was not as prepared as a result of delivering the group in a setting where he could not prepare. Thus the participants did not have as much time to discuss various aspects of the group. Also as the author was preparing the setting while they were their resulted in a lack of motivation from the group.

Study.

Following studying the group the author realised that the 10 minutes to prepare the setting had resulted in a decrease in the momentum of the group. This also had taken valuable time away from the group thus the group had to be delivered in approx. 25 minutes instead of approx. 40 minutes.

Act.

Following the group the author spoke with the Clinical Nurse Manager 2 of the relevant ward and discussed his concerns. It was then agreed that the author would have access to the setting 20 minutes prior to the educational group.
3rd Educational Group

Plan.

Following a discussion with a participant at the 2nd group. The participant reported that she felt that the groups could develop more as the author could utilise methods to increase interactions and sharing among of experiences participants.

Do.

On delivering the 2nd group I noted a lack of interaction during the educational group. I was concerned that this would result in my initiative been less effective and the momentum regarding it slowing down.

Study.

Therefore following this I reviewed the advice of the nurse following the second group. I then reviewed different methods of increasing interaction and participation on the internet.

Act.

Following this I brought a blank version of the “Talk down” poster to the 4th educational group and as participants advised me on key points of each steps I wrote them down on the blank poster’s. This provided me the facilitator to encourage various participants to reflect on their experiences.
Appendix 11

Informed Consent Document to Participate in a Research Study

Researchers Name: Francis Mc Carron

Study title: An evaluation of the impact of the Talk Downs model on self-perceived confidence of Nurses for de-escalating potential aggressive episodes.

I am inviting you to partake in this study to evaluate the impact of the Talk Downs model on how you perceive your confidence to de-escalate a potentially aggressive situation. This form will tell you about the study, but the researcher will also explain it to you. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep for your own records.

Why am I being asked to take part in this research study?
I am inviting you to partake in this study as you work as a mental health nurse on the wards in St Patricks Mental Health Services. Therefore as a mental health nurse you may have experienced situations where you have had to de-escalate potentially aggressive episodes.

Why is this research study being done?
The aim of the study is to evaluate the impact of the Talk Downs model on how you perceive your confidence to de-escalate a potentially aggressive situation.

What will I be asked to do?
If you decide to participate in this study, the researcher will ask you to complete a questionnaire to initially assess how you perceive your confidence to de-escalate a potentially aggressive episode. Following this you will be asked to partake in an educational session on de-escalation using the Talk Down model. After the session you will again be asked to complete the questionnaire to assess whether the educational session has impacted on how you perceive your confidence to de-escalate a potentially aggressive episode.

Where will this take place and how much of my time will it take?
The educational session will take place during your work hours and will take approximately forty minutes. The sessions will be scheduled for two o’clock on
Sundays. They will take place in the Nurse Recreation area in the main campus of St Patricks Mental Health Services.

**Will there be any risk or discomfort to me?**
There will be no risk or discomfort to any participant. All participants will be advised regarding the importance of confidentiality and all questionnaires completed will be completely anonymous. The author will have the pre and post assessment questionnaires identified with a small coloured to identify the matching questionnaire’s but not the individual completing the questionnaire.

**Will I benefit by being in this research?**
By partaking in this research the researcher hopes that it will have a positive impact on your confidence in de-escalating potentially aggressive episodes.

**Who will see the information about me?**
The researcher will be the only person with access to individual results. All information collected will be completely anonymous. The author will request that you do not place your name on the questionnaire.

**If I do not want to take part in the study, what choices do I have?**
This study is completely voluntary. Therefore you can end your participation at any point in this study.

**Who can I contact if I have questions or problems?**
If you have any concerns regarding this study please contact
Francis Mc Carron @ Fmccarron@stpatsmail.com Phone No. (087)7962345
Or
Adam Kavanagh @ Akavanagh@stpatsmail.com

I agree to take part in this research.

Signature. ____________________ Printed Name. ____________________
Signature of person who explained the study
________________________
## Data from the Five Educational Groups

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Appendix 13.

Poster

An Evaluation of the “Talk Down” De-escalation Model in a Mental Health Setting.
Francis McCarron 14103982
Fmccarron@stpatsmail.com

Introduction & Background
De-escalating potentially aggressive situations is a difficult and challenging experience. Staff nurses confidence and ability to communicate effectively is key to successfully de-escalating potential aggressive episodes.

Len Bowers(2) developed the “Talk Down” model to aid people in de-escalating potential aggressive episodes. Thus the author wants to evaluate this model to aid in improving nursing staff confidence during potential aggressive situations.

Aims & Objectives
Aim: The aim of this study is to investigate whether implementing educational groups using the “Talk Down”, model of de-escalation, will positively influence self-perceived confidence of nurses in de-escalating potentially aggressive episodes.

Objectives:
- Facilitate 6 educational sessions for ward based RPN’s.
- Survey the participants self-perceived confidence in de-escalating potentially aggressive episodes prior to and after the educational group.
- Establish if the content of the module is sufficient in this format to positively influence self-perceived confidence of staff nurses in de-escalating potentially aggressive episodes.

Methodology
The HSE Model(1) was chosen for its flexibility and comprehensive approach to organizational change. It provided simple and clear steps to implement change while indicating an awareness of the dynamic nature of managing change within a healthcare setting.

Initiation: The author completed various analytical tools to assess factors related to his initiative. Using a stakeholders analysis, a pest analysis, a force field analysis and assessing the culture using the competing values framework assessment.

Planning: The author planned to use educational groups to deliver the “Talk Downs” Model. Using Thackrey’s(3) survey “Clinical confidence in coping with patient aggression” prior to and after facilitating the educational group.

Implementing: The author began facilitating educational group on Sunday the 6th of March. He facilitated five educational groups with thirty four Nurses taking part.

Maintaining: The author evaluated his initiative using Kirkpatrick’s model of evaluation. The author planned to develop and sustain his change by identifying a network of individuals that with the author’s support could facilitate training on the “Talk Downs” model directly to staff on the wards they work.

Evaluation
- Five educational groups were facilitated for 34 participants.
- Their was a 7% increase in participants self perceived confidence in de-escalating potentially aggressive episodes.

Organisational Impact
1. Participants gained a 7% increase in their self perceived confidence in deescalating aggression
2. Encouraged a development in the culture by encouraging interaction among staff members regarding methods and factors in de-escalating aggression
3. Encouraged staff to become aware of there responsibility in developing their colleagues.

Conclusion
The author achieved his overall aim however to sustain the progress made the author needs to continue the development of the initiative.

References