Implementation of a Violence Risk Assessment Tool on the Medical Specialty Unit

Tracy Weber BSN, RN, MSN-CNL Student; Tara Weidner RN, MSN, CNL; Lisa Lock RN, Clinical Manager; Kristin Soland RN, MSN, QIRN; Dawn Steffes AAS; Serina Johnson DNP, RN, PHN

University of Wisconsin Oshkosh College of Nursing

Gundersen Health System®

SETTING

- Midwestern Inpatient 22-bed Medical Specialty Unit (MSU)
- Adult population with complex medical needs
  - Mental illness
  - Alcohol or substance abuse/withdrawal
  - Progressive dementia

BACKGROUND

- Violence in healthcare
  - World Health Organization (2023) defines violence [1]
    - "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."
  - During Covid-19 Pandemic [2]
    - Nurses reporting physical violence -44%
    - Nurses reporting verbal abuse - 68%
- Violence in MSU
  - Reports indicated staff were not reporting violence or injury
    - Staff desensitization
    - Concern that feelings are not heard
    - Lack of change
    - Increase staff injury
  - Aside from clinical judgement there is not a plan or a tool in place to assess individuals at the greatest risk for becoming violent in the healthcare setting

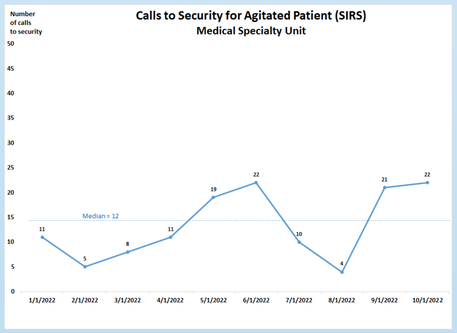
BASELINE DATA

Pre-survey

On a Likert scale Strongly Disagree (0) – Strongly Agree (5)

- Staff perception of access to adequate tools to assess a patient's risk for violence
  - Staff indicated Agree/Strongly Agree (28%)

*See graph in results

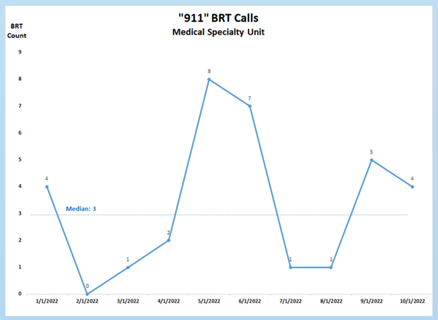


High number of Security incident reports (SIRS)

- Hospital Security documents incidents when an event occurs that involves agitation or aggression.
- Median of 12 incident reports/month

High number of emergent, "911" behavioral response team (BRT) calls

- Median of 3 - "911" BRT calls each month



PROBLEM STATEMENT

Over the past year, staff injuries have continued to occur due to aggressive acts by patients. MSU staff lack a consistent way to assess and identify a patient's risk for violence, and therefore, proactive interventions are not being put into place to mitigate violence.

IMPROVEMENT TEAM

This project was conducted by a Clinical Nurse Leader (CNL) fellow on the MSU. The project team consisted of the Clinical Manager, Administrative Director, Quality Improvement Nurse, Professional Development Nurse, providers, security staff, bedside nurses, certified nursing assistants, and CNL.

AIMS

Global Aim

To implement the Broset tool on the MSU to assist with early staff identification of patients at high risk for violence and implement a strategy to improve staff ability to avoid, reduce and/or quickly respond to violent incidents

Specific Aim

- Increase staff perception of adequate access to a tool for assessing risk for violence to 90%
- Decrease SIRS by 30%, from 12 to 8, per month
- Decrease "911" BRT calls by 50%, from 3 to 2, per month

PLAN

LITERATURE REVIEW

- Broset tool is evidence based and is more effective than clinical judgement [3,4]
  - Accurately predicts violent behavior 74% of the time in the first 72 hours of admission, which is significantly higher than nurse intuition alone [4]
- Standardizing language in care plans improves [5]
  - Communication
  - Patient care
  - Data collection
  - Care outcomes
  - Greater adherence to standards of care
- Patient-centered approach to reducing violence [6]
  - Supports recognition of imminent violence signs
  - Promotes understanding of the determinants of violent behavior
  - Minimizes the escalation of behaviors

PLAN

- Staff education provided
  - Efficacy
  - Process
  - Workflow
  - Broset guide at bedside
- Documentation audit
  - Interventions added to flowsheets for any Broset >1
  - Crisis care plan added and implemented to the individualized care plan for Broset >3

PROCESS MEASURES

- Broset tool will be completed twice a shift in 24 hours (90%) of the time
  - **Goal not met 64%**
- BRT nurse will be consulted 100% of the time if patient is high risk for violence
  - **Goal met 100%**
- Crisis care plan template will be added 100% of the time for patients with a Broset Score >3
  - **Goal met 100%**

DO

November 2022: Literature review, approval to implement the Broset, and education provided to staff. Pre-survey completed by MSU staff.

December 2022: Implemented Broset assessment, interventions, and crisis care plan in EPIC. Go live 12/14/2022.

January-February 2023: Data collection and limitation discovery.

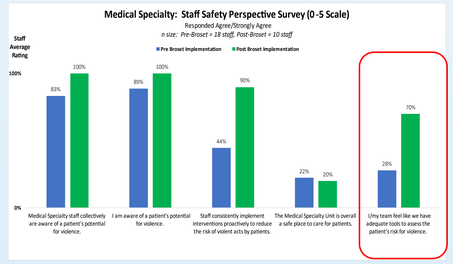
March 2023: Post-survey completed my MSU staff. Began study

ACKNOWLEDGEMENTS

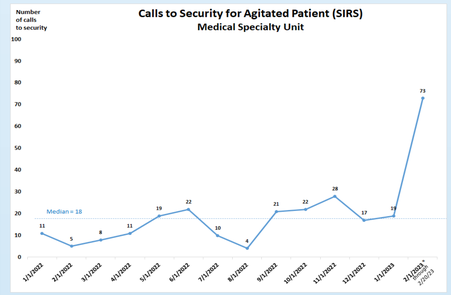
Security Department
Organizational leadership
MSU staff
Medical Media
Gundersen Medical Foundation

REFERENCES & MORE INFORMATION

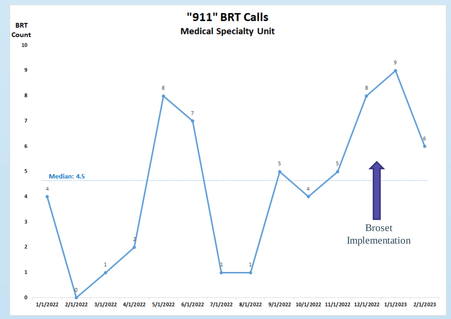
STUDY



Staff perception of availability of an adequate tool to assess for violence increased from 28% to 70%
Goal to increase to 90% not met.



Median SIRS increased from 12 to 18 calls per month
Goal of 30% reduction not met.



Median "911" BRT calls increased from 3 to 8 calls per month
Goal of 50% reduction not met.

ACT

- Run a second PDSA cycle
- Investigate opportunities to increase staff's engagement
- Hardwire complete documentation process
- Interdisciplinary team collaboration to identify next steps

LIMITATIONS

- Limited timeframe (2 months)
- Higher-than-expected violent incidents
  - Population variations
  - Increased SIRS calls and emergent BRT paging
  - High number of float pool RNs
    - Lack of comprehensive training on the Broset and crisis plans
- Identified documentation process was time laborious

IMPLICATIONS

- Consistent assessments and documentation are essential to determine whether the change has led to an improvement
- Individualized crisis care plans offered consistent interventions and enhanced communication amongst interdisciplinary team members, including security
- Collaborative debriefing emerged as an important practice that will continue to be utilized to maximize patient and staff safety
- Flagging charts when there is a known history of violence promotes early recognition of violence potential and prompts proactive planning for safety
- Identify efficient documentation process for measuring outcomes

DISCUSSION

Discussion

Overall, goals were not met, but there were identified gaps and learning opportunities identified

- Staff perception of adequate access to assessment tool. Goals were not met, but there was an increased trend (42%) in staff feeling like they had tools
- SIRS reports increased due to lower threshold to call security as part of the crisis care plan
- Average number of BRT calls increased during time frame
  - Select patients with multiple violent events impacted data; therefore, data collection over a longer time frame would be more accurate

Recommendations

- Continued evaluation of the Broset tool on the unit
- De-escalation education for all staff working on the unit
- Continue interdisciplinary collaboration to discuss areas for improvement and plan for future changes