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Development and Implementation of a Violence Risk Assessment Tool

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Section I: Acknowledgements

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Abstract

The purpose of this quality improvement project was to provide a means to effectively assess patients as they are admitted to the hospitals and to effectively communicate a patient's violent tendencies within the healthcare setting. Workplace violence is a serious problem that affects all healthcare professionals. Although serious assaults and homicides attract more media attention, the majority of workplace violence consists of non-fatal assaults. Nurses, aides, and patient care technicians suffer the most non-fatal assaults resulting in injury. Due to the growing incidence of assault and injury among healthcare workers, some states are calling for additional study on workplace violence. Healthcare organizations are mandated to develop violence prevention programs and greater reporting of incidents. Healthcare organizations have workplace prevention programs in place but still fail to protect healthcare workers from injury. Additional measures are needed to cope up with the increasing incidence of workplace violence specifically related to assaults and injuries caused by patients in healthcare settings. Research shows that the use of a violence risk assessment tool has been proven effective in attempts to prevent workplace violence. This paper will examine patient initiated violence in the workplace, explore the use of a workplace violence risk assessment tool to identify patients with propensity for violence in hospitals, and analyze the implication of the use of a violence risk assessment tool to the nursing practice.

Key words: workplace, violence, fatal, non-fatal, assault, aggressive, healthcare, risk assessment, tool

Section II: Introduction

Background Knowledge

Workplace violence is a serious problem that affects all healthcare professionals. According to the Bureau of Labor Statistics Census of Fatal Occupational Injuries (CFOI, 2010), there were 521 workplace homicides in the United States in 2009 out of a total 4,349 fatal work injuries. The fatal work injuries reported in the United States (U.S.) for 2013 was 4,585 (CFOI, 2015). The latter report is the second-lowest annual total recorded since the fatal injury census was first conducted in 1992. The overall fatal work injury rate for the United States in 2013 was 3.3 fatal injuries per 100,000 full-time equivalent (FTE) workers, down slightly from the final rate of 3.4 reported for 2012 (BLS, 2015).

The U.S. Bureau of Labor Statistics reported that the final 2013 numbers reflect updates to the 2013 Census of Fatal Occupational Injuries (CFOI) file made after the release of preliminary results in September 2014. Revisions and additions to the 2013 CFOI counts result from the identification of new cases and the revision of existing cases based on source documents received after the release of preliminary results. Although the numbers showed slight decrease in the number of fatal assaults, workplace violence is still a prevailing concern.

According to the National Institute for Occupational Safety and Health Administration (NIOSH) and the Occupational Safety and Health Administration (OSHA, 2014), workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite ranging from threats and verbal abuse to physical assaults and even homicide. Although homicides and serious assaults attract more media attention, the majority of workplace violence consists of non-fatal assaults. Workplace violence includes acts that intend to harm like scratching, spitting, pushing, and kicking (OSHA, 2012).

In addition, threats about violence also involve shouting, phone threats, non-verbal threats, and indirect and subtle remarks with threatening intentions, or threats with objects (OSHA, 2012).

The magnitude of workplace violence in the United States is measured with fatal and nonfatal statistics from several sources. The Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses (SOII) reported an estimated 154,460 nonfatal occupational injuries and illnesses involving days away from work during the 2003 to 2012 time period (NIOSH, 2014). Based on the report provided, hospitals and nursing and residential care facilities accounted for nearly three-quarters of the nonfatal occupational injuries in the sector.

OSHA (2014) outlines the risk factors for healthcare violence which include patients with mental health disorders such as dementia, schizophrenia, anxiety, acute stress reaction, and suicidal ideation. In addition, patients with history of substance abuse such as alcoholism and drug intoxication are identified as risk factors for workplace violence. Other risk factors include the use of hospitals by police for criminal holds and care of acutely disturbed, violent individuals and the increasing trend of releasing acute and chronic mentally ill patients from facilities without adequate follow-up (OSHA, 2014). Furthermore, when patients and visitors use healthcare services, it is often with feelings of anxiety, frustration and loss of control. To make matters worse, several states have concealed weapon laws and a number of people in the communities are carrying guns, making them too easily accessible when tensions are running high (NIOSH, 2012).

The difficulty in dealing with the violence often stems from the realization that violence from patients cannot be totally eliminated as there will be non-intentional verbal and physical assaults from patients with dementia or psychosis (NIOSH, 2012). In hospitals, no one really knows who is going to walk through the doors or the conditions that send patients to the hospital,

as well as their state of mind. Therefore, it is important for hospitals to be prepared and to have

an effective and robust safety and health programs to meet the safety needs of workers, patients,

and visitors.   Per OSHA guidelines (2015), the preventive strategies should include management

commitment, employee participation, hazard identification, environmental control, and accurate

reporting.

For years, hospitals have offered a variety of education and workplace prevention

programs to reduce the incidence of violence in the healthcare setting. However, there is no

system in place to assess and communicate a patient's violence potential within the healthcare

setting. Based on the data collected during review of literature, an assessment tool to predict the

violent tendencies in patients admitted to the hospital is an important aspect of a workplace

prevention program.

The Financial Impact of Workplace Violence (2011) report showed that the cost of

reacting after a serious incident has occurred is 100 times more costly than taking preventive

actions. Even without precise cost information, the overall impact and the resulting costs to

industry of reacting to incidents after they occur can be staggering, versus the cost of preventing

the violent acts in the first place. Therefore, focusing attention on safety and prevention must be

the focus going forward.

On admission, some hospitals have a set of questions for patients with history of mental

illness, suicide, suicidal tendencies, and abuse but there is a lack of simple screening tool with

acceptable sensitivity and specificity for identifying potentially violent patients. To prevent

assault and injury to the healthcare workers, methods that assess and communicate a patient's

violence potential have been developed and are being used in other countries. These methods are

not generally being used in the United States except for the ones being used by clinicians in psychiatric facilities.

The aim of this quality improvement project was to develop and to implement a macro system process for identifying and managing patients who exhibit aggressive or violent behavior, thereby potentially reducing the incidence of violence, abuse, harassment, and aggression towards healthcare staff and bystanders. The management of patients presenting with violent and aggressive behaviors is critical for the safety of the patient, staff, other patients in the area, and bystanders.

The goals of this project were to (a) reduce nonfatal assaults by 50% in two months, (b) reduce nonfatal assaults by 75% in 3 months, and (c) totally eliminate fatal assaults. Other goals for this project were (a) to examine existing policies and guidelines, if any, in dealing with aggressive patients, (b) to review existing workplace violence program to OSHA's recommendations to reflect the statement policy of a zero tolerance for workplace violence, (c) for the workplace violence prevention committee to use/implement this tool to further improve the violence prevention program already in place, (d) to educate staff on the use of the violence risk assessment tool, (e) to educate staff on recognizing, preventing, and dealing with potentially violent situations, and (f) to develop a self-training module for education and training purposes.

Local Problem

As the hospital's patient population is shifting, more patients are being admitted with mental health disorders such as dementia, schizophrenia, anxiety, acute stress reaction, and suicidal ideation. Alcoholism and drug intoxication have been identified in people who have committed workplace violence (Gillespie, Gates, Miller, & Howard, 2010). The Occupational Safety and Health Administration (OSHA, 2014) gives a comprehensive summary of risk factors

for healthcare violence, including the use of hospitals by police for criminal holds and care of acutely disturbed, violent individuals. These are the same conditions plaguing the hospitals in the Sacramento region.

An assessment of the health needs of the residents living in the service area in the Sacramento area is conducted every three years as part of a federal requirement for all hospital organizations. This assessment was enacted in 2010 and is referred to as the Community Health Needs Assessment (CHNA). Based on the 2013 Community Health Needs Assessment (CHNA) report done by a large hospital in the region from the early 2012 through February 2013, mental health concerns were a consistent health issue among key informants and focus group participants in the community. Furthermore, residents described difficulty in accessing mental health services to treat the stress and anxiety often brought on by poverty, unemployment, homelessness, and other stressors. Sacramento County rates for ED visits and hospitalization for mental health were notably higher than the state benchmark (CHNA, 2013).

The latest report from the Centers for Disease and Prevention (2014) shows that the majority of the nonfatal assaults reported in the BLS Annual Survey of Occupational Injuries and Illnesses (ASOII) occurred in the service (64%) and retail trade (21%) industries (CDC, 2014). Of those in services, 27% occurred in nursing homes, 13% in social services, and 11% in hospitals (CDC, 2014). The Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses (SOII) reported an estimated 154,460 nonfatal occupational injuries and illnesses involving days away from work during the 2003 to 2012 time period. Recognizing the impact of workplace violence and the adverse effects of fatal and non-fatal assaults, the best protection employers can offer their workers is to establish a zero-tolerance policy toward workplace

violence (OSHA, 2012). This policy should cover all workers, patients, clients, visitors, contractors, and anyone else who may come in contact with patients (OSHA, 2012).

At this medium medical center located in the Sacramento area, most patients with behavioral disturbances are admitted to one of the medical/surgical units. As a result, the prevalence of patient initiated aggression and violence has risen to an alarming rate and has led to an increased incidence of assaults among the nursing staff. This situation prompted a swift review of the existing workplace prevention program. Although a robust workplace prevention program is already in place, the gap analysis revealed a lack of a standardized risk assessment tool to identify violent patients admitted to the hospital.

As with any other strategies, prevention is the key. A literature review showed that a proactive process such as the use of a violence risk assessment tool may be the breakthrough preventive approach necessary to prevent workplace violence in healthcare (OSHA, 2015). The use of the tool warrants that all patients admitted with violent tendencies will be captured and will be given the appropriate interventions needed to effectively manage each patient. In addition, the use of a standardized tool will provide fair, valid, and reliable assessments that produce meaningful results. Moreover, the use of a standardized tool will provide clinicians and users an objective, unbiased perspective of the effectivity of the tool.

Intended Improvement/Purpose of Change

Research showed that few studies have explored the use of a violence risk assessment tool to assess and manage patients with aggressive and assaultive behavior. Based on the studies and the testimonials of the professionals who have used it, the use of a violence risk assessment tool proves to be an effective tool in reducing the incidence of violence in the healthcare setting. The use of a violence risk assessment tool will ensure that all patients with history of violence

and anyone showing signs of violence will be identified, and proper management will be initiated as soon as patients are admitted to the hospital.

After careful review of research and SWOT analysis, the focus of this project was to develop a violence risk assessment tool to bridge the gap. On admission, all patients needing hospitalization were assessed using the violence risk assessment tool to predict aggression. Using the acronym, V-I-O-L-E-N-C-E, the tool has eight criteria (see Appendix A). V-I-O-L-E-N-C-E stands for verbal and non-verbal cues such as patients being argumentative, uses profanity, loud or very soft voice, verbal threats to do harm to self or others; aggressive stance or other perceived threats; increased anxiety such as hyperactivity, finger drumming, pacing, staring, wringing of hands; increased/uncontrolled pain; other risk factors such as active paranoid delusions, hallucination with negative effect (i.e., command hallucinations), manic state; stopped taking psychiatric medications without prior consultation; long-term behavior such as history of mental illness, violence toward self or others, substance abuse; excessive alcohol or drug abuse/withdrawal symptoms; neurological abnormalities such as dementia with behavioral disturbance, delirium; carries a weapon or any object for weapon use; events such as recent separation, divorce, death of parent/spouse, child, loss of a job, friend or pet.

Risk assessment was assigned to each patient admitted accordingly (see Appendix B). The guidelines for the use of the tool is outlined in Appendix C. The nurse manager, the assistant nurse managers, and the nurses in the medical/surgical unit have shown interest and support in the use of this tool. As the project progressed, the role of each member was critical in the success of the project (see Appendix J). The trial of this evidence-based change was temporarily interrupted to obtain approval from the California Nurses Association to ascertain

that it is in compliance with the hospital's policies and procedures, with plans to resume

implementation in 2016.

Initially, the tool was implemented in the medical/surgical unit to assess change of

practice, with plans to implement the tool hospital wide and throughout Northern California.

The implementation of this project was carefully supervised and directed by this author, the

management, and the safety committee to ascertain the proper use of the tool. In collaboration

with the management and the workplace safety committee, the details of this project will be

continuously reviewed and revised accordingly to maximize the effectiveness of the tool and to

assess the needs of the hospital with the aim of reducing workplace violence.

The overall aim of this project was to pilot the Violence Risk Assessment tool at this

medium medical center located in the Sacramento area. If found effective, the use of the tool

will be expanded and implemented in all of its affiliate hospitals. The goals for this project were

(a) to implement the violence risk assessment tool to the current practice, (b) to provide a means

to effectively assess patients as they are admitted to the hospitals, (c) to effectively communicate

a patient's violent tendencies within the healthcare setting, (d) to decrease the number of violent

acts committed by patients, (e) to have the ability to capture all patients with propensity to

violence, (f) to decrease, if not eliminate, the number of assault and injuries among the nursing

staff, (g) to create an environment in which health care professionals, patients and families feel

safe, (h) to minimize the negative result associated with occupational violence for healthcare

workers such as reduced productivity, increased turnover, absenteeism, counselling costs,

decreased staff morale, and reduced quality of life, and (i) to assist hospitals to reduce cost by

implementing an efficient and sustainable approach to effectively assess and improve patient and

workers' safety while improving both short and long-term results.

Review of Evidence

The Occupational Safety and Health Act of 1970 mandates that beyond compliance with hazard-specific standards, all organizations have a general duty to provide their employees with a workplace free from recognized hazards, which are likely to cause death or serious physical harm (OSHA, 2014). Moreover, the Act's "General Duty Clause" can be used to cite employers who violate this clause for not safeguarding their organization from recognized harm and for a lack of preventive strategies to abate workplace violence (OSHA, 2014). Furthermore, the plans set by OSHA serve as guiding principles to increase awareness for both employer and employees of the risk factors for violence in the hospital and to provide strategies for reducing exposure to these factors.

Current assessment tools have been developed and are commonly used in the mental health facilities. Unfortunately, there is no simple and reliable tool that is being used to assess for potential patient violence specific for general hospitals. This QI project is poised to answer the clinical question of whether or not a violence risk assessment tool reduces the incidence of violence and increases the nursing staff's perception of safety in the hospital.

Search Methods. To gather evidence, a literature search was conducted using CINAHL, Cochrane, Midline, Proquest, PubMed, and Google scholar. A total of 32 research abstracts and references of studies were retrieved and reviewed for content. The research were mostly about workplace violence in general, but there was a paucity of research regarding the use of a violence risk assessment tool to identify violent adult patients. Due to the small number of study regarding the use of a violence risk assessment tool, there was no limit to the year of publication. All studies were all in English language using the search terms: workplace, violence, healthcare,

adult, elderly, aggression, abuse, behavior, prediction, risk, tool, hospital, fatal, nonfatal, and assault.

Kim, Ideker, & Todicheeney-Mannes (2011) conducted a prospective cohort design to evaluate the usefulness of the Aggressive Behavior Risk assessment Tool (ABRAT) to reduce violence in the clinical settings. According to the study published in the Journal of Advanced Nursing, using a specially designed risk assessment tool within 24 hours of admission was an effective way of identifying which hospital patients in the medical and surgical units would become violent. The ten-point Aggressive Behavior Assessment tool (ABRAT) was completed within 24 hours of admission using the five most common predictors of violence such as confusion/cognitive impairment, anxiety, agitation, shouting/demanding, and a history of physical aggression. It also covers staring and eye contact, tone and volume of voice, mumbling, and pacing. Fifty-six of the 2,063 patients (three percent) were involved in one or more of the violent incidents. These included 35 episodes of verbal abuse, 26 physical attacks, 15 threats of physical attack, 12 incidents where an emergency call went out to security personnel and three cases of sexual harassment. The results from this study indicate that the ten-item ABRAT could be useful in identifying potentially violent patients in medical-surgical units with acceptable accuracy and agreement between users (Kim, 2012).

Monahan and colleagues (2005) employed the public-access data from the McArthur Violence Risk Assessment Study to develop a violence risk assessment software. They validated the software on patients in Pittsburgh, PA, Kansas City, MO, and Worcester, MA. Personal factors (demographic and personality variables), historical factors (past violence and mental disorder), contextual factors (social support and social networks), and clinical factors (diagnosis and specific symptoms) were assessed. The sample selected (n=1,136), were English-

speaking patients between the ages of 18 and 40, who were of White, African American, or

Hispanic ethnicity, with a chart diagnosis of thought or affective disorder, substance abuse, or

personality disorder with a median length of stay of nine days. Interviews with patients,

interviews with persons named by the patient as someone who would know what was going on in

his or her life, and official sources of information (arrest and hospital records) were all coded and

compared.

There were 134 risk factors measured in the hospital, approximately half (70) had a

statistically significant bivariate relationship with later violence in the community (p<.05).

During the first 20 week after discharge from the hospital, at least one violent act was committed

by 18.7 percent of the patients studied. They combined the results of five prediction models to

enhance accuracy in predicting violence. Although this tool is used to ascertain the occurrence

and details of a violent incident in the community, the results of this study is highly accurate

when compared to other methods to assess the risk of violence among people hospitalized in

acute care psychiatric facilities.

Kling and colleagues (2006) examined the use and effectiveness of the Alert assessment

form. The form is part of the Alert system, used by one large acute care hospital in British

Columbia to identify patients with a propensity for violence.   On admission, all patients were

assessed using the alert system protocol, using the M55a form. A flagging system (an alert) is

implemented if a patient exhibits risk factors for aggression or violence. This process involves

placing a "V" notation in the computerized Patient Care Information System and on the patient's

chart and wristband. Patients are periodically reassessed using the M55a form. If no risk factors

are observed when the patient is reassessed with the M55a form, the flag is removed.

All reported incidents of patient violence from August 1, 2003, through December 31, 2004, were included in patient charts. One hundred seventeen violent patient charts were reviewed and compared with 161 non-violent patient charts, randomly chosen from the same time period. The overall use of the Alert assessment form for violent and non-violent patients was 75.7% and 35.4%, respectively. The assessment form was found to have moderate sensitivity (71%) and high specificity (94%). Therefore, it is reasonably effective in identifying potentially violent or aggressive patients when it is used according to protocol.

The study conducted by Teo and colleagues (2012) used a retrospective case-control design to study whether the level of training is associated with the accuracy of the clinicians' evaluations of violence potential. Teo and his team assessed the accuracy of the clinician's assessment by comparing the risk assessments that they made at the time patients were admitted to the hospital, to whether or not patients later became physically aggressive toward hospital staff members. The study included 151 patients who became violent and 150 patients who did not become violent. The psychiatric residents used the information from the Historical, Clinical, Risk Management–20–Clinical (HRC-20-C) scale, a brief, structured risk assessment tool that highlights the pre-existing assessment tools and techniques that uses patients' non-verbal and verbal behaviors to predict violent behaviors,

When the residents used the information from the HRC-20-C scale, accuracy in identifying the patient's potential for violence increased to a level nearly as high as the faculty psychiatrists who had an average of 15 years more experience. The tool is being used in a number of settings such as prisons and hospitals. However, structured risk assessment tools, such as the HCR-20-C, are not widely used in the United States.

Almvik and colleagues (2007) conducted a study involving the elderly population using the Broset Violence Checklist (BVC). The BVC tool was used to assess behaviors such as confusion, irritability, boisterousness, verbal threats, physical threats, and attacks on objects as either present or absent. It was based on a theory that an individual who exhibits two or more of these behaviors are more likely to be violent in the next twenty-four hour period. The researchers completed eight thousand eight hundred and thirty-five BVC observations in two psychogeriatric wards (n = 42 patients) and two special care units for patients with dementia (n = 40 residents).

To measure violent incidents, the study group was monitored using the Staff Observation Aggression Scale-Revised (SOAS-R). The study showed that patients in geriatric wards and residents in nursing homes who are aggressive have higher BVC scores than the non-violent patients, showing that the BVC does predict violent episodes in these settings.

Finally, Yang & Wong (2010) conducted a meta-analytic study to compare nine risk assessment tools and their efficacies in violence prediction. The report is taken from 28 original reports published between 1999 and 2008, which assessed the predictive accuracy of nine risk assessment tools. According to the research, all 9 tools predicted violence at about the same moderate level of predictive efficacy.

The study showed that at least 25% of the total variance was due to differences between tools, whereas 85% of the variance between studies was due to other factor like age, length of follow-up, different types of violent outcome, sex, and sex-related interactions. The 9 tools are essentially interchangeable if used to predict violence only. However, the authors stated that the selection of which tool to use in practice should depend on what other functions the tool can perform rather than on its efficacy in predicting violence (Yang & Wong, 2010).

Literature review showed that a proactive process such as the use of a violence risk assessment tool may be the breakthrough preventive approach necessary to prevent workplace violence in healthcare (OSHA, 2015).   The use of the tool warrants that all patients admitted with violent tendencies are captured and are given the appropriate interventions needed to effectively manage each patient. In addition, the use of a standardized tool will provide fair, valid, and reliable assessments that produce meaningful results. The use of a standardized tool will provide clinicians and users an objective, unbiased perspective of the effectivity of the tool.

The examination of the evidences was a valuable experience to determine the effectiveness in using a violence risk assessment tool to predict aggressive behaviors among patients admitted to the healthcare setting. To increase the predictive accuracy of any violence risk assessment tool, further studies are needed to see whether the use of the ABRAT, McArthur assessment tool, HRC-20-C scale, and other violence risk assessment tools can actually reduce violence in the clinical settings. Based on the studies and the testimonials of the professionals who have used it, the use of a violence risk assessment tool proves to be an effective tool in reducing the incidence of violence in the healthcare setting.

Regardless of which tool is used, further studies are needed to increase the accuracy in violence prediction. Once an aggressive patient is identified, greater efforts are needed to prevent violence to protect healthcare workers from injury. Doyle and Dolan (2006) stated that aside from the past history and behavioral cues, the current dynamic factors relating to illness and risks improves the accuracy of violence prediction.

Criteria Used to Evaluate the Evidence

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) rating scale was used to individually evaluate the six articles (see Appendix N). The JHNEBP process can be simply

described as Practice question, Evidence, and Translation (PET). The process of translating

evidence into practice begins with the identification of a practice question, issue, or concern

assessment tool proves to be an effective tool in reducing the incidence of violence in the

healthcare setting. In addition to the preventive strategies already in place, a proactive process

such as the use of a behavioral risk assessment tool may be the breakthrough preventive

approach necessary to prevent workplace violence in the healthcare settings to ensure the safety

of hospital staff and patients. The Violence Risk Appraisal Guide has been shown to be a

reliable and accurate actuarial instrument (Harris & Rice, 1997). This is one of the most crucial

steps because how the question is posed drives the remaining steps in the process.

          After the question is determined, a search for evidence is conducted. The evidence is

then synthesized and appraised. Based on this appraisal, a determination is made as to whether

the evidence supports a change or improvement in practice. If the evidence supports a change in

practice, then evidence translation occurs, the practice change is planned for and implemented.

The change is then evaluated to see if the desired outcomes were obtained. The final step in

translation is the dissemination of the results to patients, staff, hospital stakeholders, and, if

appropriate, to the local and national community (Newhouse, Dearholt, Poe, Pugh, & White,

2007).

Appraisal of Evidence with Statistics

          A critique tool was used for each article based on the study's evidence type as

experimental, quasi-experimental, guideline, systematic review, qualitative, performance

improvement project, or financial analysis (see Appendix O). Each article was reviewed for

consistency and applicability, strength of evidence, quality of evidence, and limitations. The

evidence appraisal was used to appraise each article based on a standardized scale with level 1

being the highest and level 5 the lowest. Level 1 studies include randomized controlled trials

(RCT) and meta-analysis of RCTs, level 2 includes quasi-experimental studies, level 3 includes

non-experimental studies, qualitative studies, and meta-synthesis, level 4 includes opinion of

nationally recognized experts based on research evidence or expert consensus panel (systematic

review, clinical practice guidelines), and Level V includes opinion of individual expert based on

non-research evidence. (Includes case studies; literature review; organizational experience e.g.,

quality improvement and financial data; clinical expertise, or personal experience). The quality

of each study can be categorized as (A) high quality, (B) good quality, and (C) low quality with

major flaws.

There were three articles rated as the highest strength evidence possible which makes

them the most valuable. They were randomized controlled trials or meta-analysis of randomized

controlled trials in which study participants were randomly assigned to a treatment or control

group. The strength of four studies appraised except for two reviewed was the large sample sizes

of the studies which provided sufficient power to detect statistically significant results (see

Appendix K).

Level 1, rated "B". The study by Kim et al. (2012) was a prospective cohort design

which supports the same finding in different samples of the same population. A disadvantage of

prospective cohort studies is that patient consent is generally required, which can lead to

selection bias or a bias commonly known as the Hawthorne effect. The Hawthorne effect occurs

when people who know that they are being observed (such as during a research study)

temporarily change their behavior or performance. Although the sample size was large, the

sample only included English-speaking patients. The mean standard deviation was reported with

significance at p<0.5, with a Confidence Interval of 95%, and the sensitivity and specificity were 70.9% and 89.3%, respectively.

The Study by Teo and colleagues (2012) used a retrospective case-control design study. In the case of a retrospective cohort study, the investigator collects data from past records and does not follow up patients. However, the starting point of this study is the same as for all cohort studies. The first objective is still to establish two groups-exposed versus non-exposed; and these groups are followed up in the ensuing time period. The sample size is relatively small, (N=38) for 52 patients by residents and by attending psychiatrists (N=41) for 249 patients.

Level 1, rated "A". The study by Yang & Wong (2010) is a meta-analyses study of the effect sizes of nine commonly used risk assessment tools and their subscales to compare their predictive efficacies for violence the efficacy of violence prediction. This study used a within-subject design to improve statistical power and multilevel regression models to disentangle random effects of variation between studies and tools and to adjust for study features. This means that the study used the same subjects with every condition of the research in which change over time is assessed.

Level 3, rated "B". Level 3 articles are the least valuable because they are explorative, use secondary data, and they do not produce a summary statistic, such as the study by Almvik and colleagues (2007). There were 8,835 BVC observations completed in two psychogeriatric wards, (n = 42 patients) and two special care units for patients with dementia (n = 40 residents). All the study samples were generalizable to the PICOT population and could be regenerated with strong evidence. The Kling and colleagues (2006) study involved 117 violent patient charts reviewed and compared with 161 non-violent patient charts and randomly chosen from the same time period. Overall use of the Alert assessment form for violent and non-violent patients was

75.7% and 35.4%, respectively. The assessment form was found to have moderate sensitivity

(71%) and high specificity (94%). Finally, the Study by Monahan and colleagues (2005) is a

level 3 but rated "A" with a mean standard deviation reported as significant at p<0.5, with n=

1136.

The examination of the evidences was a valuable experience to determine the

effectiveness in using an aggressive violence risk assessment tool to predict violence among

patients admitted to the healthcare setting. The use of a violence risk assessment tool allows the

user to have a frame of reference, enabling them to evaluate each patient using a standardized

form to prevent misinterpretation (CDC, 2014). To increase the predictive accuracy of any

behavior assessment tool, further studies are needed to see whether the use of the ABRAT,

McArthur assessment tool, HRC-20-C scale, and other violence risk assessment tool can actually

reduce violence in the clinical settings.

Conceptual/Theoretical Framework

The Advanced Clinical Excellence (ACE) Star Model of Knowledge Transformation was

employed as the theoretical framework to support the implementation of this quality

improvement project. The ACE Star Model of Knowledge Transformation is a model for

understanding the cycles, nature, and characteristics of knowledge that are used in various

aspects of this project, as newly discovered knowledge is moved into practice (Stevens, 2012).

The model entails the translation into practice recommendations, integration of the practice and

evaluation if the practice change on patient health outcomes and provider satisfaction

Another theory implemented for this project is the Rogers' diffusion model. Rogers

(1983) argues that certain characteristics of the innovation itself may facilitate its adoption. Other

factors influencing acceptance include promotion by influential role models, the degree of

complexity of the change, compatibility with existing values and needs, and the ability to test and modify the new procedure before adopting it. The theory deals with dissemination of an innovation (idea, practice, and product) perceived as new by an individual or group of people.

The model involves a five–step process: gaining knowledge about the innovation, becoming persuaded about innovation, decision step of adopting or rejecting the innovation, implementation of putting the innovation to use, and the confirmation step of reversing the decision or adopting the new innovation. The characteristics that Rogers (2003) identified as central to the adoption decision of the practice were the potential user's perception of the benefit to practice, its compatibility with the practice setting and population, and its complexity. For this theory to work, knowledge of the project, how to implement the change, the understanding of the change to be implemented, and the theory behind the proposed change are all essential to the success of the project.

The application of both theories to this quality improvement project are further discussed under implementation. The knowledge gained from the gap analysis and the revelation from the review of literature assisted in the development of the violence risk assessment tool. Due to the increasing incidence of violence in the hospitals, the tool will be piloted in a hospital in the Sacramento area, with plans to implement the tool in all hospitals in the northern California region.

<div align="center">**Section III. Methods**</div>

Ethical Issues

Workplace violence affects all healthcare workers but the nursing staff is at a higher risk for experiencing violence because they have the most direct contact with patients (NIOSH, 2014). The significance of violence present challenges in the application of certain ethical

principles in the workplace. Due to the complexity of workplace violence, the ethical issues

guiding each professional in terms of respect for people, beneficence, justice, and non-

maleficence, become more important and must be applied to every facet of patient care.

According to the American Nurses Association (ANA, 2010), beneficence is an ethical

principle that defines most nurses--the desire to do good, to help others, and to advocate for their

patients. When violent incidents happen, the workers feel helpless, afraid, and frustrated

(Gillespie et al., 2010). These situations present challenges in the ability of the workers to apply

these ethical principles to the workplace. Nevertheless, providers have an ethical obligation to

all patients to provide the best care possible in a safe environment.

The theory of non-maleficence and autonomy are also exemplified in the ANA code of

ethics. The ANA (2010) statement states, "nursing interventions are intended to produce

beneficial effects, contribute to quality outcomes, and – above all – do no harm" (p.15). The

ethical aspects of implementing the workplace violence risk assessment tool in the hospital and

the benefits brought about by the change are essential aspect of patient safety and preservation of

the workforce. The use of a workplace violence risk assessment tool will produce beneficial

effects to patients and their families, healthcare workers, and the hospitals.

Moreover, the use of the tool will allow the clinicians and healthcare workers to manage

violent and aggressive patients appropriately and effectively. The current policy states that denial

of treatment, refusal to give treatment or the withdrawal of treatment should not be applied to

anyone who is mentally ill or under the influence of alcohol or drugs (ANA, 2010). According

to Behr and colleagues (2005), exclusion of all people with mental illness or substance misuse

problems is unjustified and that an ethical framework needs to be established through which

decisions about provision and preservation of healthcare can be considered.

In attempts to establish such a framework, the questions about the right of an individual to receive healthcare and the conditions of the implementation of such a policy need to be addressed. The ethical aspects of implementing the workplace violence risk assessment tool will allow healthcare professionals to provide the essential treatments patients need to improve patient outcomes in a safe environment.   The effective use of a workplace violence risk assessment tool will assist nurses and other healthcare workers to do what they do best---caring for patients in the best possible way regardless of the nature of their illness.

Setting

A medium medical center located in the Sacramento area was the chosen setting for this project. The hospital provides a range of hospital care, including emergency and inpatient services. Moreover, the hospital has a robust workplace violence prevention program but has no system in place to assess the patient's propensity for violence in the hospital. Sacramento County rates for ED visits and hospitalization for mental health were notably higher than the state benchmark (CHNA, 2013).   For these reasons, this acute care hospital in Sacramento is considered most likely to influence change improvement. The use of the workplace violence risk assessment tool was piloted in the medical/surgical unit initially because most of the patients with behavioral issues and mental problems are admitted to this unit.

The inpatient unit has a 56-bed capacity with an average daily census of 36-48 patients. The number of violent patients admitted to this unit from May 2014 to April 2015 by diagnosis was 399 (see appendix G). For the past two years (2013-2015), there were 5 injuries resulting from assaults initiated by patients requiring an average of four days away from work. One employee was brutally beaten by a psychotic patient and is now on permanent disability. Due to

the high number of violent patients and the increasing number of injured nurses and patient care

assistants, the management and nursing staff were eager to enact change.

      Structure, processes, and patterns. According to the website, the hospital is composed

of seven regions and are composed of separate, but closely cooperating, organizations including

the hospital's health plans and they contract with individuals and groups for prepaid,

comprehensive health care services. The health plans contract exclusively with the medical

groups and hospitals for medical and hospital services for members and patients. In addition, the

foundation provides outpatient facilities in several states and sponsor charitable, educational, and

research activities.

      The medical groups are partnerships of professional corporations of physicians which

contract exclusively with the foundation's health plans to provide or arrange medical services for

members and patients. The organization includes the national leadership team, as well as staff

and program leads who support in a variety of business areas, including quality, finance, brand

management, communications, government relations, community benefit, compliance, human

resources, health plan operations, hospital operations, legal, and technology.

      The structure of the setting for the medical/surgical unit consists of one nurse manager

who oversees the operation of the unit and two other units and assistant nurse managers who are

frequently in the role of charge nurse in all shifts. When there is no assistant nurse manager

scheduled, other nursing staff will assume the role of charge nurse, often resulting to

inconsistencies in oversight and lack of follow up on important issues including communication

and management of violent patients. The high incidence of assault and injury prompted the

nursing staff to proactively appeal for change in their work processes. Most of the nurses have

initiated communication with the management and the leadership for change and calling for a

better system to deal with violent patients in the unit.

The patterns of the setting include the persistence of assault and injury among the

healthcare professionals. Without an assessment tool for violent patients admitted to the

hospital, there was no consistency in the admission process for these patients. In addition, there

was a lack of communication within the healthcare setting to identify violent patients and to

pinpoint their location in the hospital.

Planning the Intervention

The stakeholders identified were the patients, visitors, nursing staff, management,

leadership, hospital, contractors, and other workers. After the needs of the stakeholders were

assessed, the goals for this project were created as previously mentioned. A SWOT analysis was

performed and a survey of the nursing staff regarding workplace violence was initiated (see

Appendix J). A gap analysis and a review of literature followed. These steps revealed the need

for a simple, standardized tool to assess patients with propensity to violence. Ground work for

the project started with a discussion of the proposed performance improvement project with the

nurse manager of the unit (Medical/Surgical) and one of the assistant nurse managers.

The SWOT analysis, the gap analysis, and the literature review provided the best

recommendation for the quality improvement project. Although the hospital has adopted a zero

tolerance for violence by having an active workplace prevention program, patient-initiated

aggression remained an issue. Project deliverables include the development and implementation

of a violence risk assessment tool to identify violent patients and to reduce injury to the

workforce. This author proceeded to develop a Workplace Violence Assessment Tool (WVAT).

The risk assignment were low, moderate, and high to evaluate the degree of risk.

After the risk score was assigned, the outline of tasks under each risk category was defined (Appendix B). The guidelines for the use of the violence risk assessment tool was also itemized to assist each user in the appropriate use of the tool (Appendix C). The tool was revised three times to reflect the feedback of the nursing staff and the management. The use of the violence risk assessment tool was evaluated every 3 months to enhance the tool and to improve the safety of the nursing staff and the patients.

The project was implemented through collaboration with the safety committee. The committee is composed of nine nursing staff including this author. They met at least once a week to discuss patient safety, incidence of assaults, and evaluate the use of the tool and rate of injury among the nursing staff. When the WVAT was completed, it was presented again to the management and the interim director of nursing. With the recognition of the gravity of the situation, the nurse manager and the director of nursing showed great support for the project, encouraging the rest of the management and the nursing team to support it (see GANTT chart for the timeline).

Cost and benefit analysis of the project. The cost of planning, piloting, and implementation of this project was minimal until the final incorporation of the assessment tool into the health connect for electronic charting. The safety committee and the management are still waiting from Itechs (technology experts) for the cost of integrating the tool to Epic, electronic charting. However, to account for the cost to put together this project, this author put in an equivalent of 0.6 FTE for the last two years from the creation of the project plan (see Appendix I). This author developed the violence risk assessment tool using practicum hours for all the time spent on this project and worked in coordination with the safety committee in planning, implementation, and continuous quality improvements.

For the tool to be implemented hospital-wide, estimated resources include a part-time employee equivalent (PTEE) for a program coordinator position. The position needed is a part-time, non-benefited position with an annual cost calculated as: (0.6 FTE x 2080 x 45= 56,160). Additional costs included $5,000 annually for materials and supplies, and $3500 for the computers with one printer (Appendix I).

During the time the project was implemented, there was a big push to cut costs in the hospital. As a result, the management were instructed to encourage the employees to complete their online mandatory training and competencies during time of work, whenever they have a free time, at least 15 minutes at a time until completed so as not to incur cost. When this project was introduced, the management made it clear that there was no funding for this project. For this reason, the training and education were incorporated into the monthly, quarterly, and the annual training. A self-training module was prepared for the nursing staff as part of their training and education (see Appendix L).

The module was prepared in collaboration with the nursing staff in the emergency department (ED) and the workplace committee. It was created to equip individual nurses to navigate workplace challenges, to adequately train patients in managing violent patients, and to serve as guidelines for the nursing staff in inpatient areas to avoid injury and to promote overall safety. The ED had an existing self-training module specifically developed for the department. Some of the guidelines from the ED self-training module were incorporated to the inpatient module to maintain uniformity all throughout the hospital.

For this project, the cost of making copies were small because some of the supplies were already included in the hospital's budget. The cost of orienting and training the nursing staff did not affect the budget because they were completed during huddles and incorporated in the safety

training provided to the staff. The cost to implement and to sustain the project can be found in

Appendix I.

In 2011, there were 2,050 non-fatal assaults and violent acts reported by RNs requiring an

average of four days away from work. Of the 2050 assaults and violent acts reported, 1,830 were

inflicted with injuries by patients or residents; 80 were inflicted by visitors or people other than

the patients; 520 RNs were hit, kicked, or beaten; 130 RNs were squeezed, pinched or scratched

requiring days away from work; and 30 RNs were bitten (BLS, 2011). Using the data, each

nurse required four days away from work, a total of 8,200 days (2,050 x 4). Using an average

hourly rate of $58/hour, 8,200 days x $58 equals $475,600. Each nurse was scheduled for 8

hours a day so the replacement costs for the 2,050 nurses totaled $3,804,800 ($475, 600 x 8) for

2011. This was a huge cost avoidance to the hospital.

At this unit, an average of five nurses were injured annually for the past three years

(2010-2013). For each registered nurse (RN) injured on the job, a replacement staff had to be

utilized. On average, each nurse required four days away from work, a total of 160 hours. Each

nurse was scheduled for 8 hours a day. Using an average hourly rate of $58/hour, 150 hours x

$58 equals $9,280 so the replacement costs for four nurses in one unit alone totaled $9,280 each

year. The costs to the employer resulting from an injury due to a workplace violence includes

medical expenditures and lost wages of employees and costs due to psychological ramifications,

Moreover, when litigation occurs, legal fees and insurance administrative costs for the employers

are huge.

Responsibility/Communication Matrix Plan for the project. The matrix is found in

Appendix I detailing the scope of responsibilities for each team member, according to the

individual's role as either responsible for a task or providing assistance for the completion of a

certain task. Initial communication, planning, and the development of the tool were performed

by this author. The management and the committee were important instruments in the

implementation process, follow-up, and in the analysis and improvement of the tool. In

collaboration with the committee and the nurses, the tool was revised three times. The data

collected from the surveys and feedbacks offered useful information in the revision of the tool

and assisted in the continuous improvement process.

Implementation

The third step in the ACE Star Model of transformation is the integration of the

recommended change in practice to promote patient safety. The key members in the decision

making were the DNP student, the Workplace Safety Committee, the management, and the

leadership. The gap analysis and the evidence-based practice recommendations were presented.

The timeline for the implementation was extremely challenging because of the constant change

in the leadership and the temporary closures of a number of inpatient units and the integration of

the units.

The author was the main resource person. The safety committee assisted in every aspect

of the implementation process including the training and evaluation of the effectiveness of the

tool through the pre and post-intervention survey. The patient survey showed data regarding all

violent patients admitted to the unit, those patients identified with the use of the tool, and the

patients who actually showed violent behaviors. Two champions were designated for each shift

as the resource for the nursing staff and for enforcing the use of the tool. The guidelines for the

use of the tool involved the primary nurse assigned to the patient and the ANM (assistant nurse

manager) to complete the tool on all newly admitted patients and every time there was a change

in the patient's condition. In addition, they were also responsible for reevaluating the

effectiveness of the interventions, at least once a shift or as directed by the treatment team.

The assessment score was shared with the unit staff members, the patient's treatment

team, and the management. The THREAT team was also notified for violent incidents involving

high risks patients. The primary nurse and the charge nurse reassessed the patients at least once a

shift, each time there is a change in patient's condition or for any behavioral disturbance, as

requested by treatment team, reevaluation of interventions as needed, and if the patient is

transferred to another unit.

The tool validity will be evaluated after 3 months, 6 months, and one year respectively

after the initiation of the tool. During the evaluation, the necessary modification and

improvement will be done accordingly based on the review and recommendations from the

nursing staff, management, and the safety committee. Evaluation will also include modification

of assessment tool, modification of interventions, de-escalation methods, and revision of existing

protocol as needed. An inter-rater reliability will also be done randomly to assess the proper use

of the tool by the users.

Planning the Study of the Intervention

The Plan, Do, Study, Act (PDSA) cycle was implemented for this QI project. Planning

was initiated after this author witnessed a violent incident involving an acutely psychotic patient

and a hospital staff member. The staff member was seriously injured when she was physically

attacked by a patient she was taking care of. This incident resulted in discussions and provoked

anger and fear among the staff members, specifically the nursing staff. The author was greatly

affected and started to plan for a change in practice to protect the nursing staff. After discussion

with the management, analysis and assessment of current workplace violence prevention

program were reviewed. Literature review and gap analysis were performed.

  The violence prevention program intervention involved the development of the violence

risk assessment tool, establishing the mechanisms by which intervention components were

expected to cause changes, and choosing a quality improvement design with efforts to maximize

internal and external validity. This tool was used for the (a) identification of risk factors

associated with workplace violence from patient-initiated aggression, (b) integration of those risk

factors into structured assessment instruments to identify patients with propensity to violence,

and (c) refinement of interventions aimed at reducing violent assault and prevent injury to the

nursing staff.

  Gap Analysis. The chosen hospital has a strong workplace violence prevention program

but still lacks a simple and standardized tool to identify violent patients admitted to the hospital.

The use of a violence assessment tool to predict violent tendencies of patients admitted to the

hospital has been proven effective in reducing violence in health care (Kim, Ideker, &

Todicheeney-Mannes, 2012).   The data collected during the literature review provided important

guidelines and produced the best practice recommendation regarding the importance of using an

assessment tool for violent patients admitted in hospitals. The creation and the implementation

of a violence risk assessment tool may prove to be the missing link in the prevention of

workplace violence.

  GANTT chart. A GANTT chart was initiated to illustrate the project schedule from the

start to the finish date, showing the critical milestones of the project (see Appendix H). After the

severe beating of a worker by a psychotic patient in 2013, various aspects of the existing

workplace violence prevention program were reevaluated and stricter guidelines were adopted to

protect the healthcare workers in the hospital. The management required the nursing staff to

review the hospital's workplace violence prevention program on how to recognize and de-

escalate potentially violent situations and encouraged greater reporting of violent incidents.

However, most nurses felt like they were not fully supported by the management and that the

leadership did not consider workplace violence as a big issue unless someone is severely injured.

Although steps have been taken to prevent workplace violence, the incidence of

workplace violence persisted and more nursing staff experienced assaults from patients. In

January 15, 2014, this author approached the nursing management to bring up the challenges

facing the nursing staff in the hospital and discussed the increasing violence among the nursing

staff due to patient-initiated aggression. During the meeting, plans were made to explore

alternatives with the understanding that prevention of workplace violence needs to be the center

stage going forward.

The recommendation was to perform gap analysis and worksite analysis. The author also

raised the issue of the lack of a standardized screening tool to identify patients with propensity to

violence. Permission was granted by the nurse manager to obtain more information regarding

the current workplace prevention program and to perform a pre-intervention survey of the

nursing staff regarding the incidence of workplace violence and the acts of violence committed

toward the RNs and the certified nursing assistants (CNA). The meeting was adjourned with

plans to meet in two months to discuss the findings.

In February 12, 2014, survey of the nursing staff was initiated involving 15 nursing staff.

A tally of the violence acts initiated by patients are in Appendix D. The pre-intervention

workplace violence staff assessment survey was done to gather data and to gain perspective on

the prevalence of workplace violence, to gauge the nursing perception regarding violence in the

hospital, and to measure the violent acts committed by patients. The nursing staff were asked to

rate how safe they felt in the area they worked in, how prepared or equipped they were in

managing violent or aggressive behavior, if they experienced violence while working in the

hospital, and if so, what violent acts were committed by patients. The survey also covered the

nursing's staff opinion of whether or not the management was supportive and if the incidence of

violence was reported and if the reporting was done properly.

      The result of the survey showed a disturbing but a well-known fact among the nursing

staff. All of the participants experienced one or more patient-initiated aggression while working

in the hospital: 15 nurses experienced being shoved or pushed, yelled at or cursed, 15 nurses

were threatened with physical harm, eight nurses were scratched, six nurses were punched, five

nurses were slapped, kicked and reported having their hair pulled, and four nurses were bitten.

There were no reports of stabbing, shot at, or raped. However, there were instances when knives

or other sharp objects were found in the patient's possession.

      To provide a safe and healthy environment, a gap analysis was completed to assist in

identifying risks for violence and to put effective strategies in place to respond to the magnitude

of workplace violence. A worksite analysis was also performed through a collaborative work

with the preceptor at the hospital, a psychiatrist, the nurse manager and the assistant nurse

manager to examine the role of environmental design relating to workplace violence and to

identify and eliminate potential hazards. The result showed a number of potential hazards such

as pipes in the bedframe that could be used as weapons and other items inside the patient's room.

The unit is detached from the main hospital so security response has been an issue.

      The results of the pre-intervention survey was presented (see Appendix E), as well as the

result of the gap analysis and the worksite analysis were presented during the meeting in March

25, 2014. In attendance were the psychiatrist, safety committee, and the management. Recommendations were to coordinate with engineering to examine safety issues. As a result of the gap analysis, the attendees were in agreement to explore the use of a violence risk assessment tool to prevent workplace violence. This author will develop a violence risk assessment tool and present it to the next meeting, along with the results of the literature review regarding the effectiveness of a violence risk assessment tool.

The violence assessment tool was presented to the same group in April 8.2014. A power point presentation of the literature review was also presented to the group. They gave a favorable response and also promised their support to implement the tool. The manager agreed to pilot the project in the unit, pending the approval of the interim director of nursing. In April 22, 2015, the project was presented to the interim director of nursing. Initially, she was concerned about the amount of training needed. She stated that there was no budget available to implement this project. This author with the safety committee, and the management took responsibility to pilot the project. For the next 10 days, the staff nurses were trained to use the tool, ensuring that there were two champions for each shift as resources.

In May 5, 2015, the implementation of the tool was started. The group assisted the nursing staff in using the tool. Most of the admissions came during the day and the evening shifts. For the month of May, there were 28 patients identified with propensity to violence based on their admission diagnosis, past medical history, and behavioral cues. The patients who actually became violent were 15, about 54% of patients were accurately predicted to become violent (Appendix G). These patients were managed accordingly. For this month, the violent acts were mostly verbal as opposed to physical assault. Two nurses were pushed and one nurse was scratched as she was giving care to the patient.

The result of the implementation process was presented in June 9, 2015 to the same group and the director of nursing. She was pleased with the result and she decided that it would be best to meet at least every 2 months to monitor the progress. The survey of the patients admitted to the unit was monitored for the remainder of the implementation to examine the progress of the project. In July 16, 2014, the result of the patient admission survey was reported for the past month. Out of the 23 patients identified, 12 patients showed at least one episode of violence.

Survey was also done to determine the satisfaction rate of the users (primary nurses and assistant nurse managers). The common response was that the tool was confusing and they recommended some changes. Some of the nurses suggested to use an acronym to simplify the tool. They also recommended to add other factors to the criteria based on the patient population in the unit, such as non-compliance to medication regimen for their mental illness and recent loss such as the death of a loved one or a pet, divorce, separation, or loss of a job. This author revised the tool to include non-compliance of psych medications and recent loss as a risk factors to violence. The change was presented to the group for discussion and approval on the 30th of July, 2014.

The results of the project were discussed at the meeting with the interim director of nursing on September 2, 2014. She was very pleased with the result and encouraged the group to continue with the pilot study. The revised tool was shown to everyone and agreed to the changes made. Another suggestion given relating to the prevention of assault was to buddy up when care is being given to patients and to call security as needed. This information was given to the nurses through huddles.

For the November 5th meeting, aside from the core group, an engineering representative came to discuss the hazard issues inside patient rooms to promote safety. Other issues came up

from the nursing staff.   Many verbalized that there were not enough resources to manage

patients who have been identified as having moderate to high risk. Most of the time, they were

very short of nurses and no nursing care assistants were assigned to the unit, making it very

difficult for them to be safe. This concern was brought to the attention of the management, and

the management brought this concern to the leadership. The group continued to do the nursing

survey including the survey of the violent patients admitted to the unit.

The first meeting for 2015 was in January 7, 2015. The group met with the interim

director of nursing. The result of the surveys were presented. There were 38 patients and 39

violent patients identified for the months of November and December respectively, 65% showed

at least one act of violence for the duration of their hospital stay. Unfortunately, one nursing

assistant was hurt when she came to a patient's room without getting prior report from the nurse

assigned to the patient. One of the recommendations was for all nursing assistants to obtain

report from the primary nurse at the start of each shift.

Another issue that was discussed was a violent incident involving a patient with

uncontrolled pain. The patient became verbally abusive and grabbed the nurse when she

responded that she will call the doctor to get orders to address his pain. He wanted the nurse to

give him Morphine intravenously instead of Norco tablets. Consequently, it was suggested to

add uncontrolled pain as part of the criteria in the use of the violence assessment .tool.

For the February 4th meeting, the revision of the tool was presented. The group suggested

that it might be a good idea to implement the tool in other units. The nurse manager agreed and

she stated that she will bring it up to their managers' meeting. An issue that came up at this

meeting was the identification of patients who were repeat offenders. These were the patients

with known violence who were previously admitted to the hospital. A suggestion from the group

was to identify them through "flagging" to alert the hospital workers whenever these patients

seek care at any location of the hospital, including the laboratory, pharmacy, and other ancillary

services. The group also suggested to do a literature review regarding the subject.

A meeting on March 11, 2015 was attended by other nurses and the safety committee.

The group is composed of nurses from all inpatient units with the sole purpose of improving

patient safety and enhance nursing as a profession. They tackle all issues pertaining to patients

and nursing concerns about safety and patient care. In addition, the plan to implement the tool in

other units was also discussed. Training and education of the nursing staff was scheduled to start

on May 2015, with plans to start implementation of the tool on the first week of June 2015.

The results of the literature review regarding flagging were also discussed by two nurses

in the group. The group decided not to pursue the flagging of the patient's charts because it

would be difficult to start another project at the same time, but that it will be revisited in the

future. To get an idea about the cost, the manager was given the task to ask a representative

from Information Technology (IT) about the possibility of doing something like that and also the

ability to incorporate the violence assessment tool into health connect (electronic charting).

The next meeting was held on the 22nd of April. The attendees were the safety

committee, the management, and the interim director of nursing (DON). The DON stated that it

would be her last meeting with us because a new director of nursing was recently hired and

would start on May 2015. She stated that she will inform her about the project. She encouraged

each one to continue to improve patient safety and to be champions for continuous improvement

and to aim for excellence.

For the next month, the implementation of the tool was stopped pending the approval

from the CNA. Initially, the concern for the CNA with regards to nurses was the added

workload in implementing the Violence Risk Assessment Tool. However, after the regional

meeting, the representatives found that the use of the tool might just be what was needed to

create a stronger, more robust workplace violence prevention program. CNA finally gave the

approval for the project in August 2015. Unfortunately, there are many more obstacles standing

in the way before this project can be implemented again

A new workplace safety committee was formed, therefore a new head of the safety

committee was appointed. In addition, the CNA representative stated that all projects must be

presented and approved by a committee appointed by the hospital.   The committee is responsible

in recommending measures objectively to improve patient care, personnel utilization, health and

safety, staffing and nursing practice. This committee is composed of 10 nurses representing the

different nursing departments in the hospital. The head of the CNA and two other

representatives are also members of this committee. The project was presented to the committee

in October 14, 2015.   Per committee, the project might be resumed on January 2016 pending the

approval of the newly appointed director of nursing. The final step before the January 2016

implementation is the presentation of the use of the tool to the leadership which is expected to

take place before the end of 2015. Once approved, the tool will be implanted hospital- wide.

Nursing staff training is expected to start December 2015 or the first weeks of January 2016. If

successful, the tool will be incorporated in the hospital's overall workplace prevention program.

A PowerPoint presentation was also developed to facilitate presentations, training, and

implementation to practice.

Methods of Evaluation

The use of a violence risk assessment tool was monitored and evaluated to determine the

effectiveness of the tool, to help refine the intervention delivery, and to provide evidence for

continuing support of the project (see Appendix F & G). The evaluation also provide feedback on the effectiveness of using the violence risk assessment tool, helped determine whether the use of the tool was appropriate for the target population and whether there were any problems with its implementation and support. The evaluation also determined whether there were any ongoing concerns that needed to be resolved as the project was being implemented.

The evaluation used for this project included pre and post-intervention staff surveys. The pre-intervention survey showed data regarding patients identified as having risk factors for violence, based on the patient's diagnosis, past medical history, and behavioral cues. The important component of the post intervention survey was the actual number of patients identified with the use of the tool which would not have been identified if the tool has not been implemented. Evaluation for this project included staff satisfaction survey in the use of the tool, the perception of overall safety, and the actual reduction in staff assault and injury.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis. SWOT analysis (Appendix G) was conducted. The strengths of the violence risk assessment tool were having a simple standardized tool with high sensitivity and specificity to identify patients with propensity to violence. Other strengths of the project were the support of the management and most of the nursing staff and the approval of the interim director of nursing. Weaknesses of the project were the fact that violence risk prediction is still not strictly precise and even the very best violence risk assessments can't totally predict if a person will become violent. Other weaknesses identified were the difficulty in obtaining approval from the CNA and the leadership. Opportunities for this project were the possibility of enhancing the risk assessment tool in the future with the ability to capture most patients with violent tendencies. Opportunities include the ability to decrease assaults and injury among the nursing staff, to boost morale and improve

nursing performance, and to increase nurse retention. A major threat of this project was that the tool may not be effective in identifying violent patients admitted to the hospital. In addition, the organization was in the midst of major changes including inpatient unit integration and changes in the leadership so attempts to implement the tool was challenging. Another threat was the amount of time required to train the nurses regarding the use of the tool and trying to train nurses without incurring cost.

Return on Investment. A break-even analysis is found in Appendix I. On average, there were five nurses injured every year in the unit. For each registered nurse (RN) injured on the job, a replacement staff had to be utilized. On average, each nurse required four days away from work. Each nurse was scheduled for 8 hours a day, a total of 160 hours. Using an average hourly rate of $58/hour, 160 hours x 58 equals $9,280. Annually, the replacement costs for five nurses totaled $9,280.

During the implementation of the tool, the injury was down to one nurse needing five days away from work. The cost to replace the injured nurse was calculated. Using the average hourly rate of $58/hour for an eight hours/a day of work was 2,320. The replacement cost for the previous years were 9,280 annually, a cost avoidance of 6,960. A break-even was reached after a month of the implementation.

There are so many other costs related to workplace violence. It is impossible to overstate the costs of workplace violence, because a single incident can have repercussions. Physical and psychological repercussions were experienced by the workers as well as their families, friends, and co-workers. For years, workplace violence has generated concern among the workers especially the nursing staff, and has been a major cause of loss of productivity and morale.

While there were direct financial impacts of workplace violence, the indirect costs related

to workplace violence were astronomical. For example, the average jury award in subsequent

liability cases where the employer failed to take proactive, preventive measures under the 1996

OSHA guidelines, was $3.1 million per person per incident (IMPACT, 2006-2007). The impact

of lost wages on healthcare and nursing units may be seen indirectly in higher than average

turnover, increased requests for medical leaves, unusually high time and attendance issues, and

stress related illnesses. Loss of life and suffering cannot be measured by physical outcomes.

There were many other hidden costs involving workplace violence including increased medical

claims for stress-related illnesses, psychological counseling for all employees after a violent

incident, and time for managers and other administrators to address the violent incident.

Analysis

Quantitative and qualitative data will be used to assess the effectiveness of the

implementation of the tool in the hospital. Analysis involved staff satisfaction survey and

overall perception of staff safety, pre and post- intervention survey including the number of

violent patients admitted to the hospital and the actual number of patients identified by the

implementation of the tool, and overall feedback from the management. For this project, the

Microsoft Word and the Microsoft Office Excel were used for tables and spreadsheets.

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Section IV: Results

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Program Evaluation/Outcomes

Nature of setting and improvement intervention. The setting was a hospital with

approximately 256- bed capacity. The tool was piloted in a medical/surgical unit that operates

with an average daily census of 38-46 patients on a 56-bed capacity. Most of the patients with

behavioral disturbances were admitted to this unit. As a result, the incidence of assault and

injury to the healthcare workers were at an all-time high. Although the actual number of

incidents were not provided, the nurses and the nursing assistants were at a greater risk because

they gave the most direct patient care.

From May 2014 to April 2015, the number of violent patients admitted to this unit by

diagnosis was 399 (see appendix F). The patients identified by the use of the violence tool were

399. The actual patients who actually became violent were 267, a total of 66.91% were correctly

predicted through the use of the tool. The incidence of nonfatal assaults among the nursing staff

at the end of the one year pilot study was 43 compared to the 78 incidents prior to the

implementation of the tool. A remarkable difference of 35 nonfatal assaults prevented since the

violence risk assessment tool was implemented.

The goals of this project were to (a) reduce nonfatal assaults by 50% in two months, (b)

reduce nonfatal assaults by 75% in 3 months, and (c) totally eliminate fatal assaults. All the

goals established prior to the implementation of this project were attained. There was also a

considerable decrease in the number of injuries among the nursing staff. From 2013 to 2014,

there were 5 injuries resulting from workplace violence. From 2014-2015, there was only one

workplace violence related injury.

At the time this paper was written, the development of the tool was completed, with few

revisions done based on the nursing and patient care assessments. The tool was implemented for

one year in one unit, with plans to implement the tool hospital-wide at the start of 2016. The

implementation of the tool has been approved by the California Nurses Association, the safety

committee, the leadership, and the nursing management.

Project Evolution. The initial improvement plan evolved over time. In the beginning,

the violence risk assessment tool was named behavior assessment tool that uses patients' non-

verbal and verbal behaviors to predict violent behaviors, using the five most common predictors of violence such as confusion/cognitive impairment, anxiety, agitation, shouting/demanding, and a history of physical aggression.

After the tool was developed, alternative change strategies were considered and other elements were added to the tool to mirror the kind of patients admitted to the hospital. Other factors included were history of mental illness, inability to take medications as prescribed, pertinent negative changes in the patient's life, and a sense of loss. To simplify the tool, an acronym was used to aid the users to easily remember the information. The development of the tool also gave birth to the initiation of a comprehensive employee training which involves strategies to recognize violent patients, the implementation of measures to prevent or to diffuse angry, assaultive, and violent patients; the identification of environmental strategies, and the reinforcement of an existing protocol to effectively manage violent patients.

From the time the tool was developed, other proposals have been introduced like the flagging system. Once the patient is identified as having risks for violence, a flag system will be developed that will automatically alert all the members of the healthcare team regarding the patient's violent tendencies. Once the patient chart is opened, the flag will pop up and when the user clicks it, it will bring them back to the tool, granting them access to the information about the particular patient. It will also alert hospital workers whenever the patient is readmitted to the hospital. This project will be implemented after the hospital-wide implementation of the tool.

Guidelines for the use of the tool was also created to assist the users on how to properly use the tool. Pharmacological and non-pharmacological interventions were reassessed for effectivity and for easy access when needed. In addition, the physical set up of each room was redesigned and rearranged according to the risks identified and the possible danger each patient

poses to the workers, with ongoing efforts to promote safety among the healthcare workers, patients, and visitors. Also, the hospital's workplace violence protocol will be revised to make room for the use of the tool.

Section V: Discussion

Summary

   The key successes and difficulties in implementing the intervention.   The key success for this quality improvement project was the development of an actual, simple, standardized screening tool to identify patients with propensity for violent behavior. In the process of this quality improvement project, came the realization that the nursing staff were proactive in all aspects of workplace violence prevention and were seeking for an intervention to promote safety. When this project was presented, the nursing staff were encouraged and most of them verbalized support. A number of nurses and nurse assistants presented their views and their arguments, the pros and cons, but mostly eager and motivated to take matters into their own hands by being proactive about preventive measures regarding workplace violence. They realized that they needed to be actively engaged in effecting the changes required to protect themselves. In addition, the project triggered dialogues among the nursing staff and administration, forcing to tackle the issues of workplace violence.

   Moreover, the development of the workplace violence assessment tool caused the nursing management to revisit existing workplace prevention protocol and proposed provisions to include the implementation of the tool. Currently, the safety committee is in the process of incorporating the use of this tool in the workplace violence prevention program. In addition, environmental hazard analysis of the existing system is also currently under review.

Acknowledging the importance of this quality improvement project also requires the acceptance of the numerous difficulties encountered during the planning of implementation of the project because the setting was a hospital with many affiliates in several states. Consequently, introducing any project, more so the implementation of any project was time consuming and required patience. The difficulties in implementing the intervention were the resistance of key people regarding the proposed change, the hesitancy of the workers in taking on new projects, on top of the already daunting amount of work they are facing each day at work. Another difficulty encountered at the time the project was introduced was the numerous changes within the hospital system, with closure and integration of some units. The hospital went through major changes in leadership, with the appointment of a new director of nursing. To further exacerbate the situation, the hospital underwent major renovations the past two years, with two inpatient units still under renovation. Another hurdle for this project was gaining the support of the California Nurses Association (CNA).

The most important lessons learned. The most important lessons learned from this quality improvement project were drawn from both positive and negative experiences. Since the project is far from over, patience and perseverance are key to the success of this project and future endeavors. Enacting change is not an easy task so it was important to keep the dialogue and communication open among the workers and all stakeholders. It is important to never lose sight of the mission that was established at the start of the project, and that is to protect the workforce and to reduce the incidents of violence in the workplace.

Trying to apply project heroics can only lead to failure. It was important to involve colleagues with the same mission who were committed in making a change. When other people with the same vision were involved, a renewed commitment ensued and better results were seen.

Individual nurses may have little influence over workplace violence but collectively, nurses are poised to influence change, policy, and design to protect healthcare workers.

The lessons learned from using the tool were invaluable. Based on the pre and post intervention survey, the tool was effective in identifying patients with tendencies to violence. After the tool was revised to include the criteria based on the patient population, more violent patients were identified. As a result, incidence of assault among the nursing staff decreased considerably.

The implications for advanced nursing practice. According to the Centers for Disease Control and Prevention (CDC, 2014), healthcare is the fastest growing sector in the United States, with over 18 million workers. They face a wide range of occupational hazards including workplace violence which is considered as one of the most complex and dangerous occupational hazards in the health care environment (McPhaul & Lipscomb, 2004). Knowing the challenges facing the nursing workforce, the advanced nursing practice has a vital role in enacting changes and delivering innovative contributions to the complex health care industry.

Advanced nurse practitioners (ANP) are in a unique position to assume roles in leadership, education, delivery of cost-effective care, and other areas in healthcare. First, ANPs need to acknowledge that workplace violence exists and they ought to advocate for a safe workplace environment. In terms of workplace violence prevention, learning starts from the time a student enters the school setting. Increasing awareness of this issue among students, nurses, key stakeholders, and the public is essential to prevent workplace violence. The ANPs need to (a) continue to lobby for legislations for stricter guidelines for the safety of everyone who works in the hospitals and for the protection of patients and visitors, (b) continue research and education in the area of workplace violence, (c) encourage greater reporting of violent

incidents, and (d) be a part of the solution by actively enforcing the guidelines and implementing

measures to prevent workplace violence.

The use of a workplace violence risk assessment tool with high sensitivity and specificity

will assist clinicians including the ANPs to screen patients with a predisposition to violence. The

use of this tool will assist in tracking patients wherever they are in the hospital and will aid in

modifying the existing protocol to effectively manage patients while they are in the hospital. The

tool will also help to flag these patients to ensure adequate follow up in the outpatient setting and

also track those patients when they are readmitted to the hospital.

Relation to Other Evidence

Compare and contrast study results with relevant findings of others. Although there

are a number of articles and studies regarding workplace violence as a whole, there is a paucity

of research regarding the use of a workplace violence risk assessment tool in particular. The

research specific to workplace violence risk assessment tool gave the best recommendation for

this quality improvement project. See Appendix O for the summary of articles related to the use

and importance of using a screening tool in preventing workplace violence and decrease the

incidence of assaults and injuries among the healthcare workers. Due to the variance in the

result of each study, using the tool alone is not conclusive. Therefore, further research and

studies are needed to validate the use of a violence assessment tool in identifying violent patients

admitted to the hospitals. The research evidence appraisal tool used was the John Hopkins

Nursing Evidence-Based Practice (see Appendix N).

Similarities and differences in other settings reporting success/failure. This QI

project incorporated the principles and precepts of previous studies from all over the world.

Nurses around the globe are experiencing the same, if not worse, workplace violence in the acute

care hospitals. However, the literature consistently indicated that preventive measures such as the use of a workplace violence risk assessment tool are beneficial and effective in identifying patients with predisposition to violence. Although this tool is mainly used in psychiatric facilities in the United States, research shows that this tool may be useful in any setting and that further studies are needed to explore the tool's efficacy.

One major difference of this tool from other screening tools is that the criteria used was conformed specifically to the patient population admitted to the acute care hospital. The screening criteria was not limited to the observed behavioral cues such as agitation, pacing, drumming of fingers, staring, Other factors included were verbal threats of self-harm and to hurt others, ineffective pain management, delirium episodes, history of mental illness, acute episodes of mental illness, experienced recent loss, patient stopped taking psychiatric medications without prior consultation, history of alcohol and drug abuse, and other factors that might attribute to behavioral changes as deemed by the clinician (see Appendix A).

Barriers to Implementation/Limitations

Possible bias and factors affecting generalizability. Turner (2015) stated that structured approaches yield more accurate assessments and that such assessments prevent cognitive biases that can distort outcomes, such as giving greater risk for more prominent events and discounting risk when it is deemed less dangerous. She also mentioned another common bias namely confirmation bias which pays attention to information that confirms a person's current belief structure. This can lead to racial profiling and may lead to inaccurate actual risk assessment. In the workplace, bias may be committed if risk assessments are based on the user's own beliefs and background and when the user's decisions are based on rationale. Having a structured violence risk assessment tool counteracts possible cognitive biases.

A single factor that might limit its generalizability is that this tool was developed to conform to a hospital setting. However, the violence risk assessment criteria is the same regardless of the setting for implementation. Management and follow-up are in accordance to the protocol of each facility.

Barriers to implementation. Currently, there is no funding for this project. The risk of not being able to complete the implementation process remains an issue. To sustain this project, a coordinator is needed to continue to see it through. A great possibility is that the safety committee will take over the responsibility of overseeing this project but it remains to be seen. The implementation process requires sustained cooperation from the nursing staff and the management. Since this the very first time a violence assessment tool is being introduced to this hospital, the process of implementation is slow and would require continuous follow up with those involved throughout the course of the implementation. Furthermore, a new director of nursing was recently appointed. Although she already gave her permission to continue with the implementation, her full cooperation is crucial in the success of this project.

Interpretation

When this project was proposed, there were other competing projects in progress to promote patient safety and to improve quality of care. Some of those projects have been initiated years ago and are just starting to take shape. This project was piloted within the previously established time frame and the expected outcomes were fully observed after a year of trial. The project is already approved for hospital-wide implementation to start in 2016. At some point, modifications to improve future performance and opportunity costs and actual financial costs will be realized on an ongoing basis.

The most important aspects of the implementation planning were the success in the trial of this tool, the cooperation of the nurses, management, and the safety committee. The implementation of the workplace violence risk assessment tool assisted in strengthening the existing protocol, aided in analyzing the current environmental hazards, and gave the nursing staff some sort of encouragement that help is on the way. Another exciting aspect of the implementation planning was the knowledge that more nurses volunteered to be part of the implementation process and management were willing participants.

Dissemination plan. It is not enough to acknowledge that workplace violence do exist in the hospital. Advocating for a safe workplace involves increasing awareness among the nursing staff. In addition, ongoing education programs are essential in establishing and advocating for an environment with a zero tolerance for violence.

To share the valuable information about the project, the result of the pre-intervention workplace assessment survey was distributed to the nurses. The information was shared during the huddles, meetings, and presentations. One-to-one teaching was also done to customize learning. To enhance learning, poster presentations were also utilized. The evaluation of the use of the tool and the improvements to the tool were shared to the nursing staff and to the management every two months. After the post-intervention survey was completed, the result and analysis were presented with key lessons learned, strategies for improvement, changes made over the course of time, with Q & A portion to address the questions, concerns, and feedbacks.

The implications of this work for future professional and staff development.
Initially, there was no available information regarding the rate of violence and reports of injured employees in the hospital to do an analysis except for what was known in the unit. However, for this project, the analysis was based on the patients admitted to the hospital with identified risk

factors to violence potential, the actual number of patients who exhibited violent behaviors, the number of employees injured from patient-initiated aggression, and the number of violent acts committed by patients toward the nursing staff. The project also provided invaluable information regarding the magnitude of violence in the workplace and the negative effects of the impact of workplace violence on productivity, absenteeism, nurse retention, job satisfaction, and increased cost to the employer.

The tool reported efficacy in determining violent potentials in patients during their hospital stay. The results of the project will undoubtedly assist future research and projects about the benefits of using a workplace violence assessment tool in preventing violence in the hospitals. However, the tool was developed specifically for a hospital setting, but it may prove to be effective in any other setting when revised according to the patients seen in the healthcare setting.

Conclusions

Spector and colleagues (2014) analyzed the data from research studies on nurses' exposure to violence from more than 150,000 nurses. The analysis revealed that 36.4% of nurses reported having been exposed to physical violence, and 66.9% were exposed to nonphysical assault. The study also showed a report of 91 shooting incidents inside US hospitals between 2000 and 2011. Acknowledging that workplace violence exists and recognizing the enormity of the negative effects of workplace violence are realities that everyone should be made aware of in order to meet the challenges associated with violence. Confronting the issue of workplace violence is critical in working towards a zero-violence environment. Some people think that hospitals are safe. Unfortunately, one could not be further from the truth.

A startling revelation from the Joint Commission's Sentinel Event Database (2010) reported that 256 assaults, homicides, and rapes occurred in hospitals since 1995. Furthermore, it was reported that the number of incidents might be higher due to underreporting. Advocating for a safe workplace environment and establishing a comprehensive prevention program become top priorities. Preventive measures includes ongoing education and training, lobbying for stricter regulations, encouraging reporting of violent incidents, management and employee participation, hazard identification, and worksite analysis (OSHA, 2012). As part of preventive measures, the use of screening tool is essential in promoting safety among the nursing staff.

Violence risk assessment tools are inexact science. Although the tool will assist the user in identifying violent patients by estimating the risk of violence, predicting the when and how the violence will take place is a challenge. According to Turner (2015), violence risk assessments don't predict violent behavior. However, knowing the risk of violence will influence the nursing staff's decision about response and the degree of protection needed for safety. The challenge also lies in the fact that even the very best violence risk assessments can't totally predict if a person will become violent or the nature of violence (Turner, 2015). People at high risk may refrain from violence, whereas those at low risk can, under certain circumstances, act in uncharacteristically aggressive ways. Either way, knowing about risk can guide the nursing staff's decision- making to increase the odds of staying safe.

The use of a violence risk assessment tool for use in healthcare is in its infancy. Although the use of violence risk assessment instruments for hospitals has been proven effective in identifying violent patients, violence risk prediction is still not strictly precise. Analysis and personal bias may influence the assessment process and as such will continue to provoke debate. Clinicians clearly need to be able to demonstrate the rationale behind their decisions on violence

risk. Recent developments in research on violence risk prediction have shown tremendous

progress. However, more studies are needed to follow up and bridge the accuracy gap.

Section VI: Other Information

Funding

Currently, **t**here is no funding for this project. Fortunately, after the project was

presented to the safety committee, the members have expressed support and have given their

commitment to pursue this project to completion. An alternate plan for sustainability is the

creation of a position for an advanced practice nurse to coordinate the successful implementation

of this project with plans to permanently integrate this project to the hospital's workplace

prevention program.

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Section VIII: Appendices

Appendix A: Violence Risk Assessment Tool

Instruction: Score each item if criteria is present and total score

	Assessment Criteria	Points	Score
V	**Verbal and non-verbal cues** argumentative, uses profanity, loud or very soft voice, verbal threats to do harm to self or others; aggressive stance or other perceived threats	2	
I	**Increased anxiety** hyperactivity, finger drumming, pacing, staring, wringing of hands; Increased/uncontrolled pain	2	
O	**Other risk factors** active paranoid delusions, hallucination with negative effect (i.e., command hallucinations), manic state; stopped taking psychiatric medications without prior consultation	2	
L	**Long-term behavior** history of mental illness, violence toward self or others, substance abuse	1	
E	**Excessive alcohol or drug abuse/withdrawal symptoms**	2	
N	**Neurological abnormalities** dementia with behavioral disturbance, delirium	2	
C	**Carries a weapon** or any object for weapon use	2	
E	**Events** recent separation, divorce, death of parent/spouse, child, loss of a job, friend or pet	1	
	TOTAL SCORE		

Date and Time: _____ **Completed by (RN):** _____

No Risk = 0
Low Risk = 1-2
Moderate Risk = 3-5
High Risk = 6 or higher

Do not solely rely on the risk score when determining the appropriate interventions, consider the overall condition in determining risks for violent behavior.

❖ **A patient who is a 51/50 or forensic involvement is automatic high risk.**

Appendix B: Violence Risk Assessment Tool (Risk Assignment)

LOW RISK:

- Document score in the medical record.
- Search patient and patient's immediate environment for harmful objects, remove potentially dangerous items from room.
- As part of the zero tolerance for violence, educate regarding consequences of action.
- Offer PRN medications, utilize interventions and reassess every 30 minutes for effectiveness as needed.
- De-escalation management per protocol. Attempt at verbal de-escalation.
- Assess patient's room assignment and move closer to nurse's station, if possible. Place in high visibility room or room with line of sight.
- Ensure to protect patient's privacy.
- Protect patient's physical well-being.
- Assess privilege level.
- Notify MD as needed.

MODERATE RISK

- Document score in the medical record.
- Search patient and patient's immediate environment for harmful objects, remove potentially dangerous items from room.
- Remove patient belonging from the room and place in a secure location.
- Determine, if possible, patient's intent by asking,
  "Are you angry at anyone? If yes, who?" "Are you thinking about hurting yourself?"
  "Are you thinking about hurting anyone?" "Do you have a plan?"
  ++ Is the patient able to verbally interact with staff?
  Assess for elopement risk.
  Provide actions that will help patient to refrain from hurting self or others, provide sitter/security as needed.
- Assess privilege level.
- Assess patient's room and move closer to nurse's station as needed. Place in a high visibility room or room with line of sight.
- De-escalation management protocol.
- Assess patient for assault or suicide ideation, protect patient's well-being. If patient is injured, modify patient's treatment plan as needed.

- Ensure the privacy of the patient.
- Notify MD as needed.
- Offer PRN medications as needed, reassess for effectiveness every 15 mins. or as needed.
- MD assessment determines need for psychiatric evaluation and further interventions.
- If is ascertained that patient and/or visitor is at risk for violence or if a weapon has been found, the nurse should notify the supervisor and security should be immediately called to the scene.
- Security to begin direct observation: "Security Behavior Observation Tool.
- RN completes a behavior observation assessment for visual appearance.
- A Reporting Responsibility Form (RRF) must be completed to include the following:
    - **(a) Describe the event.**
    - **(b) Describe the weapon.**
    - **(c) Condition of patient following the event.**
    - **(d) Signature of nursing personnel writing notes.**
- A Security Incident Report will be completed.

HIGH RISK

- Document score in the medical record.
- Search patient and patient's immediate environment for harmful objects, remove potentially dangerous items from room.
- Remove patient belonging from the room and place in a secure location.
- De-escalation management per protocol.
- Determine, if possible, patient's intent by asking,
  "Are you angry at anyone? If yes, who?" "Are you thinking about hurting yourself?"
  "Are you thinking about hurting anyone?" "Do you have a plan?"
  ++ Is the patient able to verbally interact with staff?
  Assess for elopement risk.
  Provide actions that will help patient to refrain from hurting self or others, provide sitter/security as needed.
- Assess privilege level.
- Assess patient's room and move closer to nurse's station as needed. Place in a high visibility room or room with line of sight.
- Assess patient for assault or suicide ideation. Protect patient's well-being. If patient is injured, modify patient's treatment plan as needed.
- Ensure the privacy of the patient.
- Notify MD as needed.
- Offer PRN medications as needed, reassess for effectiveness every 15 mins. or as needed.
- MD refers patient for psychiatric evaluation and further interventions immediately.
- Notify Threat Management Team (TMT) to guide, coordinate, and handle the specific threat at the department or building.

- If the patient and/or visitor is determined to be at risk for violence, or if a weapon has been found, the nurse should notify the supervisor and security should be called to the scene immediately.
- Contact the Sacramento Sheriff Department if there is a reason to believe the patient is in possession of a weapon.
- Security to begin direct observation: "Security Behavior Observation Tool.
- RN completes a behavior observation assessment for visual appearance.
- A Reporting Responsibility Form (RRF) must be completed to include the following:
  - **(e) Describe the event.**
  - **(f) Describe the weapon.**
  - **(g) Condition of patient following the event.**
  - **(h) Signature of nursing personnel writing notes.**
- A Security Incident Report will be completed.
- Debriefing after a violent incident.
- Offer/provide Employee Assistance Program (EAP) for employees involved.

Appendix C: Guidelines for Use of the Violence Risk Assessment Tool

1. The nurse assigned to patient and the ANM (Assistant Nurse Manager) will complete tool on all newly admitted patients.
2. Assessment score will be shared with unit staff and the patient's treatment team. Notify the THREAT team as needed.
3. Any or all of the interventions may be implemented by the treatment team as necessary based on the patient's total score.
4. Reassess by the nurse assigned to patient with the ANM for the following:
   a. Every shift
   b. Change in patient's condition.
   c. As requested by treatment team.
   d. Reevaluation of interventions as needed.
   e. Transfer to another unit.
5. Tool validity- after 3 months, 6 months, a year.
   a. Modification of assessment tool.
   b. Modification of interventions.
   c. De-escalation methods.
   d. Review of protocol.
   e. Inter-rater reliability at the 3-month interval.
6. Staff members must be educated about parameters for violence assessment and the possible preventive and pro-active interventions.
7. The Violence Prevention Enforcement Team should review the components of the current training program and consider to develop an algorithm to support decision-making.
8. Administrative support for debriefing after a violent episode occurs, provide assistance to affected staff members as needed.
9. Quality improvement based on a recent violent episode so the staff can learn from the events and be able to respond better in the future.
10. Violence assessment tool must be reviewed on an ongoing basis.

++The coordinator will retain the scoring forms to allow for retrospective review.

Appendix D: Workplace Violence Staff Assessment Survey

❖ **Rate how safe you feel from workplace violence overall or in each area in the hospital**

	Not Safe				**Extremely Safe**
	①	②	③	④	⑤
1. Nurses Station A	☐	☐	☐	☐	☐
2. Nurses Station (Main entry)	☐	☐	☐	☐	☐
3. Nurses Station B	☐	☐	☐	☐	☐
4. Inside a patient room	☐	☐	☐	☐	☐
5. Overall Safety in the unit	☐	☐	☐	☐	☐

❖ **How prepared or equipped are you in managing violent /aggressive patients?**

Not Prepared   *Extremely Prepared*
☐   ☐   ☐   ☐   ☐

❖ **If you have experienced workplace violence while working in 1 West, did you report it?**

Yes ☐   No ☐

❖ **When you reported a violent incident, did you feel supported by management?**

Yes ☐   No ☐

❖ **Indicate if you have experienced the following while working in the unit:**

	Yes	**No**		**Yes**	**No**
Pushed/shoved			Yelled at		
Hair Pulled			Cursed		
Pinched			Kicked		
Bitten			Threatened with physical harm		

Scratched			Sexually assaulted		
Slapped/punched			Stabbed/Shot		
Hit with an object			**Other (specify)**		

Appendix E
Pre-intervention Nursing Survey: Acts of Violence
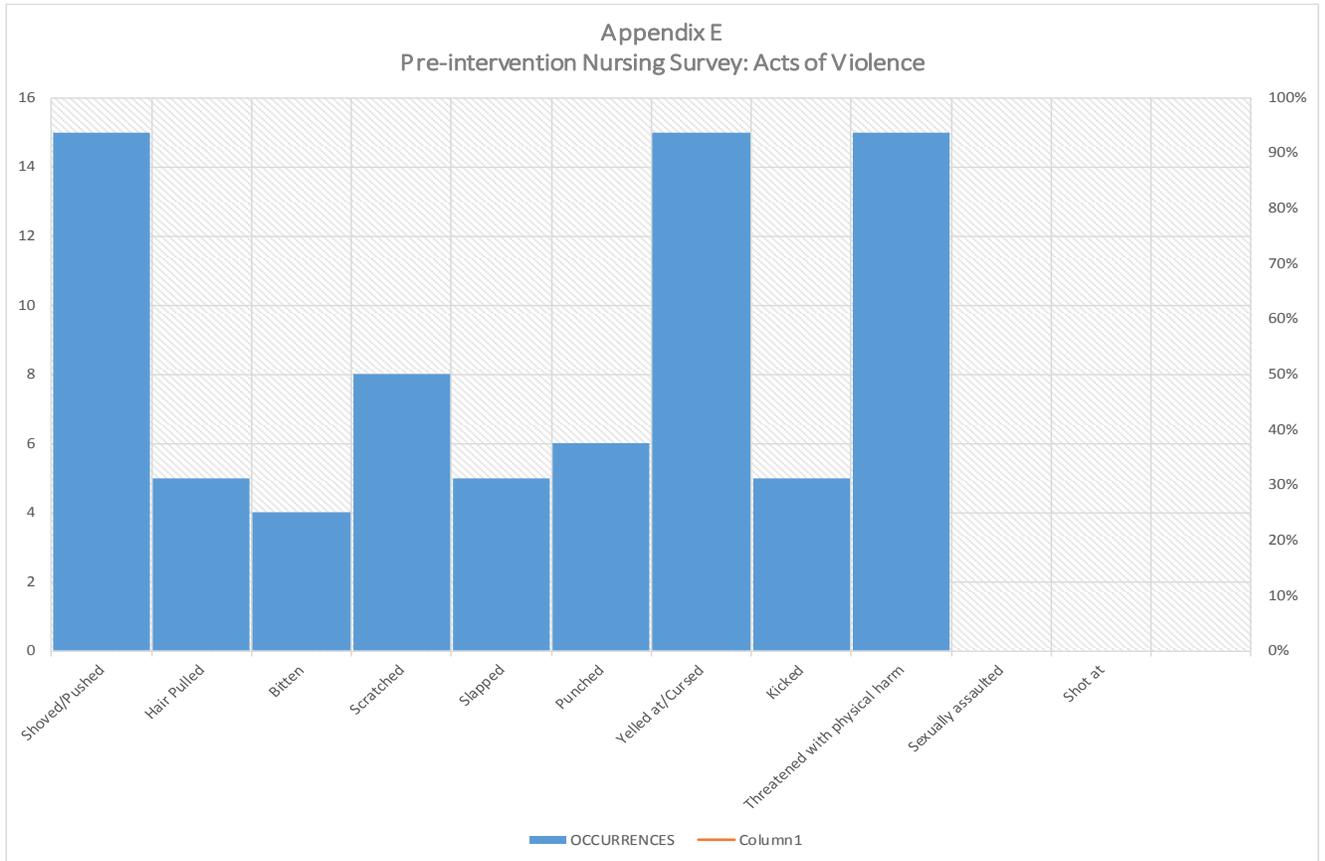
PROBLEM DATA

Acts of Violence	OCCURRENCES	PERCENT OF TOTAL	Column1
Shoved/Pushed	15	19.23%	
Hair Pulled	5	6.41%	
Bitten	4	5.13%	
Scratched	8	10.26%	
Slapped	5	6.41%	
Punched	6	7.69%	
Yelled at/Cursed	15	19.23%	
Kicked	5	6.41%	
Threatened with physical harm	15	19.23%	
Sexually assaulted	0	0.00%	
Shot at	0	0.00%	

Appendix F: Post-Intervention: Acts of Violence Committed by Patients

Appendix F
Post-intervention Nursing Survey: Acts of Violence
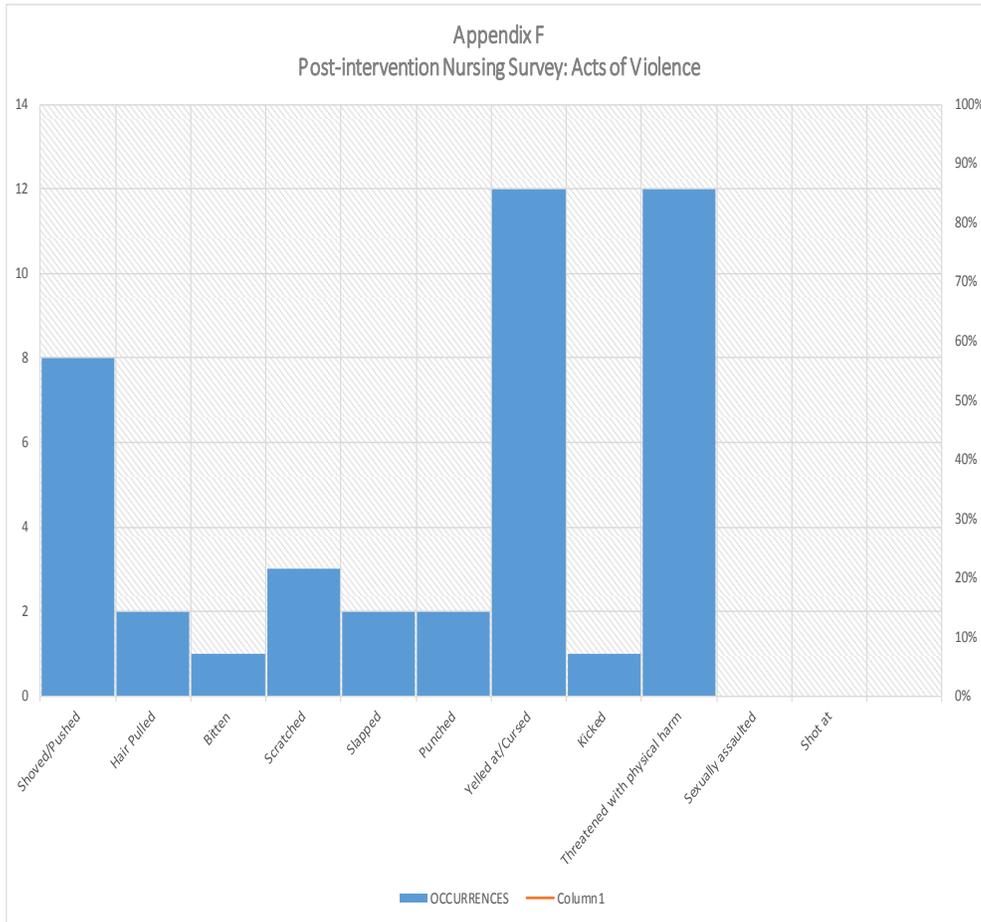
PROBLEM DATA

Acts of Violence	OCCURRENCES	PERCENT OF TOTAL	Column1
Shoved/Pushed	8	18.60%	
Hair Pulled	2	4.65%	
Bitten	1	2.33%	
Scratched	3	6.98%	
Slapped	2	4.65%	
Punched	2	4.65%	
Yelled at/Cursed	12	27.91%	
Kicked	1	2.33%	
Threatened with physical harm	12	27.91%	
Sexually assaulted	0	0.00%	
Shot at	0	0.00%	

Appendix G: Violent Patients Admitted per Diagnosis in 2014

Violent Patients Admitted to 1 West			2014													IDENTIFIED	ACTUAL	
			PATIENTS ADMITTED TO 1 WEST WITH PROPENSITY TO VIOLENCE (MAY 2014-APRIL 2 P															
			May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April				
																TOTAL	TOTAL	
Dementia			2	2	0	3	1	4	5	7	2	5	7	3		41	24	
Dementia with Behavioral disturbance			5	4	7	6	5	4	6	8	7	7	5	4		68	68	
Schizophrenia			2	1	0	3	5	2	0	2	1	1	2	1		20	10	
Bipolar Disorder			2	0	1	0	2	1	1	2	0	1	2	3		15	10	
Delirium			1	3	3	2	2	1	5	1	1	3	2	5		29	29	
Alcohol Withdrawal			3	1	0	1	1	4	3	2	3	2	4	4		28	20	
History of Alcohol Abuse			2	0	1	2	1	1	2	1	0	2	3	3		18	9	
History of Drug Abuse			1	4	2	0	3	3	4	3	3	1	0	2		26	15	
Pain Disorders	(started in Jan.2014)	x	x	x	x	x		2	2	4	2	4	3	2		19	9	
Anxiety Disorder			1	5	2	2	4	4	3	4	4	2	5	5		41	15	
Depressive disorder			1	1	0	0	2	0	1	1	0	0	2	1		9	3	
Suicidal			2	0	1	1	0	1	1	0	0	2	1	2		11	5	
Psychosis			6	2	3	2	5	1	5	4	4	3	7	8		50	50	
Total			28	23	20	22	31	28	38	39	27	33	43	43		399	267	66.91%

Appendix H: GANTT Chart

DNP PROJECT TIMELINE AND SCHEDULE OF IMPLEMENTATION OF THE VIOLENCE RISK ASSESSMENT TOOL

		Milestones	Deliverables	DNP Paper

DATES		TASKS			Milestones	Deliverables	DNP Paper
JANUARY	2014						
15		Met with the manager and the assistant manager in 1West to discuss workplace violence in general			■		■
		performed gap analysis and worksite analysis.					
FEBRUARY							
12		Performed a pre-intervention survey of the nursing staff regarding the incidence of workplace violence			■		■
		Discussed the result of the survey with the safety committee, psychiatrist, and the management					
MARCH		Discussed the result of the gap analysis, worksite analysis, and the need for having a structured screening tool					
25		met with a represnetative from the engineering department to address worksite hazards					
APRIL		A powerpoint presentation regarding the use of the tool was developed					
8		The violence assessment tool was presented to the same group					
22		the project was presented to the interim director of nursing					
5-May		Started the pilot study in 1 West					
9-Jun		The result of the implementation process was presented					
16-Jul		the result of the survey of patient admission was reported for the past month.					
		Revision of the tool to include criteria - risk factors such as non-complianc and recent loss					
30-Jul		Presented the revised tool to the preceptor, psychiatrist, management, safety committee					
2-Sep		Met with the group and the interim DON ; buddy up to care for violent patients					
5-Nov		Met with engineering to address hazards inside patient's rooms					
	2015						
7-Jan		The group met with the interim director of nursing. The result of the surveys were presented.			■		■
		Due to injury, all PCTs to get report fom primary nurse at the start of the shift prior to patient care					
		Suggestion to revise the tool by adding the criteria: uncontrolled pain					
4-Feb		Presented the revised tool to the preceptor, psychiatrist, management, safety committee					
11-Mar		The safety group met with CLC to discuss the implementation of the tool					
		flagging patient's chart was also discussed					
22-Apr		Met with the interim DON for the last time anew DON was hired					
August		The tool was apporved by CAN					
14-Oct		Met with the PPC for the first time					
11-Nov		met with PPC and the head of safety committee, powerpoint presentation					
Jan	2016	Planned implementation of the tool hospital-wide					

Appendix I (a): Cost/Benefit Analysis (Nurse Replacement)

Replacement for an average of 5 nurses injured and are away from work:

In 2011, there were 2,050 non-fatal assaults and violent acts reported by RNs requiring an average of four days away from work (BLS).

Using the data, each nurse required four days away from work, 8 hours/day, with an average hourly rate of $58, the calculation is as follows:

 2,050 nurses x 4 days = 8,200 days.

8,200 days x $58 equals $475,600.

Each nurse was scheduled for 8 hours a day so the replacement costs for the 2,050 nurses totaled $3,804,800 ($475, 600 x 8) for 2011.

In the unit, an average of five nurses were injured annually for the past three years (2010-2013).

For each registered nurse (RN) injured on the job, a replacement staff had to be utilized. On average, each nurse required four days away from work, a total of 160 hours. Each nurse was scheduled for 8 hours a day:

 Using an average hourly rate of $58/hour, 150 hours x $58 equals $9,280 so the replacement costs for four nurses in one unit alone totaled $9,280 each year.

Appendix I (b): Annual Costs/Benefits for the Implementation of the Tool (HOSPITAL)

Program coordinator = (0.6 FTE x 2080 x 45= 56,160)

Annual Cost to Implement the Project				Benefits			
	2014	2015		Preventing injury			
Indirect Cost				Prevent cost due to injury and liability			
papers	300	300		Potential savings of	$563,342.40/per year		
pens, pencils	400	400		due to nurse replacement (5/year)			
markers, papers	600	600					
Make copies	1000	1000					
Items for presentation	1000	1000					
Computers (2)	3200	3200					
Printer	300	300					
Miscellaneous	1000	1000					
meetings	1000	1000					
Direct Cost							
0.6 FTE	56,160	56,160					
Total	64,660	64,660					563,342.40
Break-even in approximately one month after the implementation of the project.							

Appendix J: SWOT Analysis

Strengths	Weaknesses
1. The strengths of the violence risk assessment tool were having a simple standardized tool with high sensitivity and specificity to identify patients with propensity to violence. Multidisciplinary support of the management and the nursing staff in the unit(Med/Surg/Telemetry units). 2 .Approval obtained from the California Nurses Association. 3. The interim CNO expressed approval and support. 4. The tool was easy to use. 5. The tool assisted in effective communication. 6. Fostered team work and management support. 7. Made safety a top priority, number of incidents is likely to decline.	1. The use of the tool is in it's infancy and as such may not be able to capture all patients with propensity to violence. 2. Charting at this time may be time consuming, the tool is not in the EMR yet. 3. Lack of support and cooperation from the individual nurses and the individual members of the workplace violence prevention team. 4. The amount of time required to train the nurses regarding the use of the tool and trying to schedule time for nurses to attend the training
Opportunities	**Threats**
• Opportunity to publish and market the use of the tool. • The potential to prevent injuries • Increase productivity • Can impact morale • Number of violent incidents is likely to decline. • For the employers, the potential to save money by reducing the incidence of assaults and the possibility of litigation. • The potential for this tool to be implemented throughout California and all over the United States.	• Potential resistance from individual nurses. • Lack of budget for this project. • Leadership may not approve the use of this tool hospital-wide. • Lack of continued support, interest, and cooperation from the management and nurses.

Appendix K: Responsibility/Communication Matrix

Responsibility & Communication Matrix	DNP	Safety Committee	Primary Nurse	Management
Develop a violence risk assessment tool	R	S	S	S
Develop a training module for the nursing staff	R	S	S	S
Survey of all violent patients admitted to 1 West: identified and patients who actually became violent	R	R	S	S
Implement the tool in 1 West and hospital-wide	R	S	S	S
Develop a survey and perform pre-intervention and post-intervention survey	R	S		S
Analyze results of pre/post intervention	R	R		S
Revise the tool based on the result as needed	R	S		S
R= Responsible				
S= Supports/ Assists				

Appendix L: Self Training Module

SAFE MANAGMENT OF AGGRESSIVE BEHAVIOR
A SELF-TRAINING MODULE
(This module was developed due to increased concerns by Kaiser Permanente and by the
government over increased ED violence. Some modifications were made for inpatient use.)

+++++Kaiser Permanente's concern over the problem has resulted in a Policy Statement of "Zero
Tolerance for Workplace Violence:"

++++The California government has demonstrated its concern in CAL OSHA Guidelines, which
regard workplace violence as a "dire safety issue," and in the enactment of California Health and
Safety Code §§1257.7 and 1257.8 (AB 508), which requires that all employees assigned to the
ED receive initial and annual violence training as of July 1995.

GOALS AND BACKGROUND

The goals of this self-training module are to:
A. Increase your awareness, skills, and confidence in early recognition of, and effective response
to aggressive behavior in the unit.
B. Teach you how to defuse aggressive behavior before it escalates to the crisis stage.
C. Teach you how to respond in the event a crisis develops.

FACTORS CONTRIBUTING TO INCREASED HOSPITAL VIOLENCE

Our society is becoming an increasingly violent place. Some factors that have contributed to this
include:
A. Increasing violence in newspapers, television and moves
B. Increasing numbers of handguns
C. Increasing numbers of gangs
D. Financial pressures and personal problems
E. Influence of drug abuse
F. Influence of alcohol abuse
G. Closure of many mental health programs
H. Breakdown of the family

GENERAL PERSONAL SAFETY GUIDELINES

The best defense we have against a violent attack is knowledge and preparation. Now that you
are aware of the high incidence of violence in society, you should always follow some general
rules to protect your personal safety. Have a personal safety plan that will help you no matter
what situation you find yourself in. Here are some ideas:

A. Be alert to your surroundings at all times, no matter where you are.
B. Use your common sense to avoid situations and places that could be dangerous.

The following are some common myths about violent acts:

MYTH 1:

    Only young, attractive women are raped.

TRUTH:

    All women are vulnerable to rape. In fact, even men and boys can be targets.

MYTH 2:

    Rapists attack only when their sexual desires are high

TRUTH:

    Rape is a crime of violence and power. It is a way for one person to dominate and humiliate another. It is not a sexual act but an act of violence.

MYTH 3:

    Your assailant has to be a man; only a man can hurt you.

TRUTH:

    A. Women commit violent crimes too. Many people make the mistake of trusting a woman in a situation where they wouldn't trust a man. Don't let gender determine whether you think a situation is dangerous.

MYTH 4:

    Violent crimes are committed only by strangers.

TRUTH:

Forty percent of all personal crimes are committed by the people the victim already knows (family, co-worker, date, etc.)

REVIEW:

    A. Name 5 factors that increase the risk of violence in the hospital?

1.

2.

3.

4.

5.

    B. What are two ways you can help maintain your personal safety?

1.

2.

    C. What are two policies or guidelines that Kaiser has enacted to deal with increasing incidents of violence in the hospital?

1.
2.

TIPS FOR SAFETY IN THE EMERGENCY DEPARTMENT

DO	DON'T
Always be aware of your surroundings - Explore the unit until you know the layout. - Pay special attention to the exits - Note the places where you could be cornered - Where do you feel most vulnerable? - Where do you feel most safe? **Always be aware of people you don't know** - All visitors should have a visitor pass on his or her chest. - Question all people who don't have a Kaiser ID or a visitor pass and show them where they can obtain one. - Enforce the visitor policy. **Be aware of people who look suspicious** - If you sense danger or are uncomfortable about a person, alert another staff member to your concerns. - Know where your security alarms are and know the telephone extension to call security for an emergency **(CODE GRAY x5444)** When you call Code Gray, tell the officer who answers that you need help and give your exact location. Security will respond quickly with several officers. **Use a buddy system** - Always have a team member who knows where you are. **Always approach the following persons with caution and, if possible, with a buddy:** - angry patients or visitors - psychiatric patients - patients who are under the influence of alcohol or chemicals	**Don't enter a room without leaving yourself a clear exit** - the door should be behind you, not between you and the patient. - Don't close the door, if possible. **Don't have scissors, pens, reflex hammers, etc. protruding from your pockets** - These items are potential weapons which could be used against you. **Don't lean over a patient with a stethoscope or ID necklace hanging from your neck.** - These items could be used to choke you. **Don't ever take a weapon directly from a patient.** - If you suspect a patient has a weapon, notify Security promptly. - If a patient volunteers to hand over a weapon, have him or her place it on a table and step back. *Security should retrieve the weapon, not you!*

CLOTHING STANDARDS

We don't often think of clothing when we are faced with a potentially violent situation, but what we wear can be used against us!

REMEMBER
Clothing should be loose, comfortable and allow freedom of movement.

Shoes should be low-heeled, closed toe, and non-skid.

All earrings, including studs, can be pulled, thereby tearing the ear.

Necklaces, ties, scarves, bracelets, long hair and beards can be pulled, causing injury.

THE ASSAULT CYCLE

Psychologists have researched behavior patterns which are involved in violent behavior. They have identified 4 levels of behavior that accompany violent activity. Violent behavior is complex and, although categorizing it into 4 levels is an oversimplification, it is helpful for employees to be aware of these four levels, so that they can learn to interrupt (of defuse) the behavior before it gets to the acting out stage. These levels are:

1) Anxiety,
2) Defensiveness,
3) Acting Out, and
4) Tension Reduction

Here are some characteristics of each stage:

LEVEL ONE – ANXIETY

At this stage you notice a definite change in a person's behavior. This may be seen as any of the following:
a) Increased nervousness
b) Restlessness, such as finger drumming, wringing of hands, staring
Interventions: Attempts to defuse a situation will be most successful in this first level.
Ask yourself "What does this person want or need that he/she is not getting?"
Be supportive, non-judgmental, and empathetic.
Acknowledge the person's concerns

LEVEL TWO – DEFENSIVENESS

At this stage, the person is getting increasingly frustrated because his/her needs are still not met. The person is starting to lose rationality. (S) he is often belligerent and challenging at this stage.
Interventions: 1. *State which specific behavior is inappropriate.*

> *2. Indicate why the behavior is inappropriate.*
> *3. Clearly spell out the consequences of continued behavior.*
> *4. Pause.*
> *5. Listen skillfully to what the person is saying.*

E.g., *"Your screaming is disturbing other patients. If you continue screaming I will have to ask you to leave."*

Sometimes a reasonable show of force is necessary at this stage. This could be another staff member, or Security.

LEVEL THREE - ACTING OUT

At this stage there is a total loss of control or physical acting out (assaultiveness).
At this point you should definitely not be alone with their person and Security may have to be summoned.
Interventions: 1. Use safe control and/or restraint techniques to control an individual.
               2. Often a show of force is all it takes.
               3. Use physical restraint as a last resort.
               4. Always call 911 at the first sign that someone is likely to be injured.

LEVEL FOUR - TENSION REDUCTION

There is a considerable buildup of energy in the first three levels, and after a person who has been out of control is finally restrained, there will most likely be a reduction in tension. You may notice the following:
a) Muscles are relaxed
b) Breathing has returned to normal
c) May act frightened
d) May be remorseful

KEYS TO EFFECTIVE INTERVENTION

1. Be aware of your tone of voice.
Experts say that only 10-50% of what we "say" is verbal. The remaining message is transmitted in our body language and tone of voice.

2. Respect personal space.
Invasion of someone's personal space will escalate anxiety. Personal space an area of 18 to 30 inches around our bodies. We all consider this "space" as an extension of our bodies. So when you approach a disruptive or agitated person, you want to respect his or her personal space as much as possible, to avoid escalating the situation. (Another good reason not to get too close is to avoid injury to yourself!)

3. Be aware of your body position. Avoid a "toe to toe, eye to eye" "showdown" position. When approaching an individual, be mindful that you send a nonverbal message in the motion and posture of your body. Frowning, staring, yelling, clenched fists, staring all can further escalate a tense situation. Remember, that the more a person loses control, the less (s)he listens to your words. Instead (s)he "hears" your body language.

The best way to approach an individual is to stay 3 feet away, at an angle, to avoid a "showdown" stance.

4. Listen. Empathetic listening is an active process used to find out what a person is saying. This is one of the most effective steps in defusing a tense situation, but it is usually overlooked.
a. Don't be judgmental
b. Don't ignore or fake attention
c. Carefully listen to what the person is really saying, behind his/her angry words.
d. Use silence.
e. Clarify with the patient "Is your concern that.........?" to make sure you understand what (s)he is saying.

5. Permit verbal venting whenever possible. Remain calm, rational, and professional. Your response will have a direct effect on the individual.

6. Ignore challenge questions. When the person challenges our position, authority, training, policies, etc., redirect the individual's attention to the issue at hand. Answering a challenge question will just fuel a power struggle.

7. Use physical techniques as a last resort. Always use the least restrictive method of intervention possible. Using physical techniques on an individual who is only acting out verbally will unnecessarily escalate the situation.

REVIEW

    A. Name 5 ways that you can protect your safety:

        1.

        2.

        3.

        4.

        5.

B. Name the 4 Levels of the Assault Cycle, and an effective intervention at each of the
    first 3 stages.

    1. Stage 1:

Stage 1 intervention:

    2. Stage 2:

Stage 2 intervention:

    3. Stage 3:

Stage 3 intervention:

    4. Stage 4:

Stage 4 intervention:

C. Name 3 keys to effective intervention:

1.

2.

3.

PREDICTING VIOLENCE
CHARACTERISTICS OF AGGRESSIVE AND VIOLENT PERSONS

3 TYPES OF VIOLENCE

There are 3 major categories which usually cause violence:

    1. Violence due to psychiatric/emotional disorders
30-40% of all psychiatric-related violence comes from patients with schizophrenia.
20% comes from patients with personality disorders. The bipolar patient who is in the manic
phase is particularly dangerous, since his or her euphoric, grandiose, and initially friendly
behavior can quickly change to anger and aggression with even minor demands.

    2. Violence due to alcohol/drug intoxication

These persons often end up in the ED after some violent incident that was sparked by their intoxication, e.g., altercation in bar. Patients on "crack", methamphetamine, or PCP can be particularly combative. These patients may continue to manifest behavioral issues in the units and end up with withdrawal symptoms while admitted in the hospital.

It may be a patient's visitor who is intoxicated. Impaired visitors are more likely to become agitated by long waits or when limits are placed on their behavior. Impaired visitors may immediately escalate to the "acting out" stage, if limits are placed upon their behavior. So it is better to call Security at the first sign of potentially violent behavior by an intoxicated visitor. Thus, you should probably not tell the intoxicated visitor, "If you don't calm down I will call Security to escort you out." It would be better to call Security first, and then limit the visitor's behavior.

     3.   Violence due to anger over long waits are common.
PAIN AND SUFFERING are the most common denominators in patient violence. It is not uncommon for staff to become desensitized to a patient's suffering, in order to cope with the demands of the job. In order to avoid waiting, patients or visitors often resort to attention-getting (aggressive) behavior.

FACTORS WHICH MAY POINT TO POTENTIAL VIOLENCE
***These factors aren't intended to stereotype people, but merely to provide a means for staff to assess the situation and be on the alert.

These factors may indicate potential violence:

1. People with a past history of violence
- This factor is the #1 indicator of future violence.
2. People under the influence of drugs or alcohol
- Alcohol is the most common substance which leads to violence.
3. Gang affiliation
- Rival gang members show up in the hospital to "finish the job" on an injured gang member.
4. People with certain tattoos
Pathologists report that certain tattoos are associated with gangs or with incarceration, often for violent crimes. Some examples are monochrome tattoos that are made in prison by melting carbon-paper for ink and using needles. These home-made tattoos I be of penitentiary numbers, or anti-social messages, such as "Born to lose," "Death before Dishonor," "Misfit.")
5. Grief-stricken relatives
7. Health care workers have been injured or killed after making death announcements to the bereaved.
8. Loss of Control
People who have had some control taken away from them, such as an abusive parent or spouse who is prevented from seeing his children or spouse.
9. Misinterpreting medical treatment
    Family members or friends can misinterpret medical treatment as harmful to someone they
    Care about. E.g., a woman attacked a resident because she saw the resident inserting a
    chest tube into her son's chest.

MEDICAL PROBLEMS THAT MAY CAUSE VIOLENCE

Sudden psychotic behavior in a patient who has no history of psychosis may be triggered by a medical problem. Drugs or alcohol may exacerbate the situation. Some common causes are listed below:

A. hypoglycemia
B. hypoxia
C. head trauma
D. meningitis
E. drug intoxication or withdrawal
F. HIV virus complications
G. sepsis
H. brain abscesses
I. hepatic encephalopathy
J. endocrinopathy, including Cushing's Syndrome
K. CO_2 retention
L. CNS tumors
M. paradoxical drug reaction in elderly

Although new-onset psychiatric conditions are possible, remember that they rarely occur after age 45. The peak onset of schizophrenic or manic disorders is adolescence or young adulthood.

CLUES TO IMPENDING VIOLENCE

A. Subtle Clues
1. Gut Feeling
If you feel frightened or uncomfortable with a patient, don't ignore the feeling; always call for backup or support.
2. Provocative Behavior
This includes teasing, hostility, and unreasonable requests
3. Angry Demeanor
This includes menacing facial expressions, cursing, and hostile remarks
4. Manic States
5. Intoxication
6. Delirium
Fluctuating levels of consciousness make these patients unpredictable
7. Confusion and fear in the elderly

B. Overt Clues
1. Motor Restlessness
This includes fidgeting, shifting about, and rocking, clenching fists. Pacing around the waiting room is a serious red flag.
2. Loud, angry, forceful speech.

3. Agitated behavior
Such as knocking over furniture, pounding walls, throwing things
4. Threats to injure or kill someone
This type of person is more dangerous if (s)he describes a victim or details of a plan
5. Known history of violence
6. Presence of weapons (Call 911 at once)

REVIEW

A.   What are the 3 major types of violence?

1.

2.

3.

B.   Name 3 clues of potential violence.

1.

2.

3.

C.   What is the #1 indicator (most important clue) of potential violence?

1.

D.   What are 5 medical conditions which could cause violent behavior?

1.

2.

3.

4.

5.

E.   What is the drug which most commonly leads to violent behavior?

1.

F.   List 2 subtle clues which may warn of potential violence.

1.

2.

G.   Give an instance when an employee should immediately call 911.

1.

BASIC STRATEGIES TO AVOID HARM
When you have a potentially assaultive patient or visitor, the standard courtesy and respect which are expected in all customer interactions is even more crucial.
Remember that empathetic verbal intervention is the most effective method of calming an agitated, fearful, panicky individual.
However, if verbal de-escalation techniques do not work, and the individual quickly becomes assaultive, you'll need to be able to respond quickly to protect yourself. Here are some key principles which underlie most common strategies to avoid harm:

A. Get away and get help, rather than try to force an aggressive patient or visitor to comply with your requests. There is no potential violent situation that requires your heroics.
B. Watch your body language. When dealing with patients or visitors who are standing up, position yourself to the side, not directly in front of them. This serves two purposes:
1. It is harder for the person to hit or kick you when you are to his or her side;
2. It is less threatening to the individual if you are not in his or her "personal space."
C. Undress the patient. If the person who you suspect may become violent is a patient, bring him or her to an exam room and have the patient change into hospital clothing as soon as possible. Generally a person is less likely to attack if disrobed.
D. Call Security if you feel the tension is building up or that the
situation is getting out of control. An early show of force is often better than waiting for the situation to develop into a crisis. Never warn the person that you will call security if they don't behave, this may be enough to put them over the edge. If you feel you should call Security, do it without telling or threatening he person. And remember, if you ever feel that someone is about to be injured, call 911.

FIVE EVASIVE MANEUVERS DURING A PHYSICAL ATTACK
Of course it is best to prevent the situation from escalating to this crisis level, but if you are not successful in preventing the escalation, here are some maneuvers to keep in mind.

1. Escape first if you can!
*The best maneuver is to run away and get help. You should be familiar with the layout of the unit and know all of the escape routes. If you are unable to escape you should:
2. Keep your distance.
a. Never allow the agitated person to come within 30 inches of you.
b. If you are right handed, stand with your left foot at least thirty inches from the individual. Pull your right foot back about a foot behind your left foot. Your weight should be balanced on your dominant (right) leg. Your body should be facing 30 to 45 degrees away from the person, rather

than facing directly at him. By doing these things you have made a strong and stable foundation with your legs, and positioned yourself so that it will not be easy for the individual to kick or punch, or grab you. (You are 30 inches away and beyond his or her reach.) By standing at a slight angle and 30 inches away, it is also less threatening to the individual.

3. Be Prepared to Block yourself

a. Put both hands in front of your face, your palms facing the individual, fingers toward the inside, left had a few inches farther away from your face than the right hand.

4. Remain Calm and Talk Calmly

a. While you are performing steps 2 and 3 above, continually and calmly try to de-escalate the situation by telling the individual that you don't want any trouble that you don't want to fight.

b. Make certain that when you perform steps 2 and 3 that your tone of voice and body language show that you are trying to de-escalate the situation and that you are not confronting or threatening the individual.

5. Block and Escape

a. If you have followed steps 1 to 4 at the first sign of escalation to potential violence, you will be ready for a punch, kick or other attack. Your body is on a stable foundation if you are pushed, so you won't fall. If you are punched, you should try to deflect the punch with your forearm (your hands are already up and in front of your face) and at the same time step back and escape, after the punch. If you are kicked, try to deflect the leg with your hands and step back and escape after the kick. If you have maintained your distance, the individual will not be able to reach you.

b. In cases where you are grabbed, choked or held, always remember that the assailant has certain vulnerable areas. If you need to strike back in order to escape, don't waste your time trying to strike at an area of his or her body which is covered by muscle.   If the assailant is large, you won't even hurt them.

Vulnerable areas of the body are:

i.	the eyes
ii.	the throat, directly above the sternum
iii.	the groin
iv.	the shins

No matter how the assailant is holding you, you should be able to kick or punch the groin, kick the shins or knees, put a finger in the throat directly above the sternum, or two fingers in the eyes. If you are required to perform any of these things in order to escape, do it forcefully. You don't want to annoy the individual, you want to make him release you.

c. As soon as the assailant releases you, run for safety and help.

ASSISTANCE FOR EMPLYOYEES WHO ARE VICTIMS OF VIOLENCE

Workplace violence is traumatic! When we are a victim of violence, or when we observe our co-workers being abused or attacked, it can be extremely distressing. Individual reactions to violence will vary, depending on the victim's unique life history. Some typical emotional reactions are:

A. shock
B. anger

C. disbelief
D. anxiety
E. irritability
F. fears

There also may be physical reactions, including

A. sleep disturbances
B. eating disturbances
C. increased use of alcohol/medication/drugs
D. headaches
E. muscle tension

There also may be changes in relationships with family members and co-workers, performance difficulties, increased absenteeism.
Kaiser Permanente recognizes the importance of providing support and assistance to a employees/physicians who have been victimized by violence. The Employee Assistance Program (EAP) is available to respond to such crisis situations by providing a range of services. All EAP services are provided by experienced, professional counselors with expertise in trauma response and crisis intervention. Services are voluntary, confidential and provided free of charge for employees and their dependent family members.

REVIEW

A.   What is the most effective intervention for calming an agitated, fearful, or panicky individual?

1.

B.   Name 3 basic strategies to avoid harm.

1.

2.

3.

C.   What are the 5 evasive maneuvers to be used during a physical attack?

1.

2.

3.

4.

5.

D.   Name 3 typical emotional reactions to being a victim of violence?

1.
2.

3.

E.   Name 2 typical physical reactions to being a victim of violence?

1.

2.

F.   Where can a victim of violence go for help and support at Kaiser Permanente?

1.

OBTAINING MEDICAL HISTORIES FROM A PATIENT WITH VIOLENT BEHAVIOR

It may be difficult to obtain an accurate history from a violent behavior. Make sure you don't overlook any of the following sources of information:

A. Patient
B. Medical Records
C. Family, friends, others accompanying patient
D. Pre-hospital staff (EMS, police)
E. Information in patient's possession (wallet, Medic-Alert bracelet)

THINGS TO DO IN TAKING A HISTORY FROM A VIOLENT PATIENT

A) Remember it's an on-going process and you may have to put pieces of information together to get the full story.
B) Establish the patient's mental state early on. You may need to go to other sources for information.
C) Introduce yourself...."I'm here to help....I need your cooperation."
* Your approach to the patient and the rapport you establish early on...the care you demonstrate....will go a long way toward getting the patient to disclose their history.
D) Acknowledge the patient's feelings
* You don't have to agree, but it may help to emphasize. This is especially true if the patient is in a lot of pain, angry with the way they've been treated, or just upset over long waits.
E) Maintain your objectivity - don't personalize the patient's anger
*It is natural to want to get defensive when a person takes out their anger on you,

but remember the patient is not really mad at you personally.
F) Know your own limits - know when to call someone else in to take over
* Some of us have higher tolerance levels than others. Know when you are losing control of a situation. The indicators are:
1. your voice is rising
2. you are judging the patient
3. you are becoming angry with the patient

G. Be clear about setting limits on the patient's behavior
1."I need you to regain control and stop screaming, and then we can talk about......"

THINGS NOT TO DO IN OBTAINING A HISTORY FROM A VIOLENT PATIENT

A. Never get to close (closer than 30 inches).
*Always leave yourself an exit and know where it is.
B. Don't go in alone. Have a backup with you.
C. Don't yell at the patient
1) Never raise your voice to the patient, even to tell them to shut up.
2) If the patient is getting out of control, it is better not to mirror that energy level.
3) Know when to set limits, know when to be empathetic, but don't get into a screaming match.
D. Don't "cop an attitude" and treat the patient with disrespect.
*Such provocative behavior is asking for trouble.
E. Don't shame the patient into submission. Don't say:
1) "Others are sicker than you..."
2) "You should have thought about that before..."
3) "Don't you know.....?"
F. Don't get sucked into the whole violent scenario.
*Sometimes when violence erupts, it attracts a lot of people. Suddenly ten staff members can be involved and it can easily get carried away. Maintain professionalism at all times and coordinate your efforts with other staff members. Heroism is not advisable.

APPROPRIATE USE OF PHYSICAL RESTRAINTS
Review medical center policy on Restraints.

APPROPRIATE USE OF MEDICATIONS AS CHEMICAL RESTRAINTS
Medications may help to restrain a violent person. The following are some considerations to remember concerning medications as restraints:

A. Physicians will often avoid tranquilizing the patient as long as possible, as not to cloud the diagnostic picture.
B. Chemical restraints require a doctor's order.
C. Usually, chemical restraint is a final resort to calm an extremely agitated, violent patient who poses a threat to himself or others; when physical restraint alone has not calmed the patient down enough to allow effective diagnosis and treatment.
D. Try to gain the patient's cooperation whenever possible. Offer them an active role in their treatment whenever possible.

E. Inform the patient of what you are doing as you are doing it. "You seem to be restless and nervous. This medication will make you feel calmer and help to stop the voices you are hearing."
F. Tell the patient what medicine you are administering.
G. Monitor patients for postural hypotension and, if neuroleptics are used, dystonic reactions.

REVIEW:

A. List 4 sources of information that might be used in obtaining a medical history.

1.

2.

3.

4.

B. List 4 things you should do when obtaining a history from a potentially violent patient.

1.

2.

3.

4.

C. List 4 things you should not do in obtaining a history from a potentially violent patient.

1.

2.

3.

4.

D. List 4 important factors that should be remembered when administering chemical restraints.

1.

2.

3.

4.

Appendix M: Training: Use of a Violence Risk Assessment Tool (POWERPOINT)

THE DEVELOPMENT AND IMPLEMENTATION OF A VIOLENCE RISK ASSESSMENT TOOL IN HOSPITALS

▶ MIRA AIDASANI-DIWATA

In The News

▶ *Nurse, 69, fighting for her life after being beaten by patient in the hospital who savagely kicked her to the ground as she treated him*

▶ Evelyn Lynch, 69, was beaten by Kwincii Jones, 40, on Friday afternoon in Brooklyn.

▶ Lynch suffered head injuries and multiple fractures.

▶ Rushed to nearby hospital for brain surgery and is now in a critical condition.

▶ Jones is set to face attempted murder charges.

▶ It is believed that Jones has mental health problems.

(Nye, 2014)

▶ Read more: http://www.dailymail.co.uk/news/article-2555424/Nurse-fighting-life-beaten-patient-hospital-savagely-kicked-ground.html#ixzz39C7V8k59

Incidence of Workplace Violence

❖ Spector and colleagues (2014)

❑ analyzed data from research studies on nurses' exposure to violence from more than 150,000 nurses.

❑ The analysis revealed that 36.4% of nurses reported having been exposed to physical violence, and 66.9% were exposed to nonphysical assault.

❑ The study also showed a report of 91 shooting incidents inside US hospitals between 2000 and 2011.

Incidence of Fatal Assaults

▶ Workplace violence is a prevailing problem that affects all healthcare professionals.

❑ According to the Bureau of Labor Statistics Census of Fatal Occupational Injuries (CFOI, 2010), there were 521 workplace homicides in the United States in 2009 out of a total 4,349 fatal work injuries.

❑ The fatal work injuries reported in the United States (U.S.) for 2013 was 4,585 (CFOI, 2015).

❑ The fatal work injuries reported in the United States for 2012 was 3.4 per 100,000 full-time equivalent (FTE).

❑ The overall fatal work injury rate for the United States in 2013 was 3.3 fatal injuries per 100,000 FTE workers, down slightly from 2012 (BLS, 2015).

Definition of Workplace Violence

❑ Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite ranging from threats and verbal abuse to physical assaults and even homicide.

❑ Although homicides and serious assaults attract more media attention, the majority of workplace violence consists of non-fatal assaults.

. ,OSHA, 2012)

Incidence of Nonfatal Assaults

❑ An estimated 154,460 nonfatal occupational injuries and illnesses involving days away from work during the 2003 to 2012 time period (NIOSH, 2014).

❑ Based on the report provided, hospitals and nursing and residential care facilities accounted for nearly three-quarters of the nonfatal occupational injuries in the sector.

Consequences of Workplace Violence

▶ Workers experience :

❑ Anger

❑ Anxiety

❑ Shock

❑ Apathy

❑ Self-blame

❑ Sense of helplessness

❑ Others have difficulty returning to work and may have changes in relationships with co-workers

(OSHA, 2012)

Risk factors for Workplace Violence

❑ Mental health disorders-- such as dementia, schizophrenia, anxiety, acute stress reaction, and suicidal ideation.

❑ Substance abuse- alcoholism, drug intoxication

❑ The use of hospitals by police for criminal holds and care of acutely disturbed, violent individuals.

❑ Increasing trend of releasing acute and chronic mentally ill patients from facilities without adequate follow-up.

❑ Frustrated patients and their families often encounter long waiting times, high medical costs, and fragmented services.

▶ (OSHA, 2014)

Preventive Measures per OSHA Guidelines:

▶ The preventive strategies should include:

❑ Hazard identification

❑ Environmental control

❑ Accurate reporting

❑ Employee participation

❑ Management commitment

Identified Gap In Practice

❑ On admission, some hospitals have a set of questions for patients with history of mental illness, suicide, suicidal tendencies, and abuse.

❑ There is no system in place to assess and communicate a patient's violence potential within the healthcare setting.

➢ Review of literature gave the best recommendation---------An assessment tool to predict the violent tendencies in patients admitted to the hospital is an important aspect of a workplace prevention program.

Recommended Change in Practice

▶ Implementation of a Violence Risk Assessment Tool:

❑ To identify patients admitted to hospitals with propensity to violence.

❑ To effectively communicate a patient's violent tendencies within the healthcare setting.

❑ To decrease the number of violent acts committed by patients, and

❑ To decrease assault and injury to the nursing staff.

Literature Review: Study 1

Kim, Ideker, & Todicheeney-Mannes, (2011)

▶ A prospective cohort design to evaluate the usefulness of the Aggressive Behavior Risk assessment Tool (ABRAT) to reduce violence in the clinical settings

▶ studied more than 2,000 patients admitted to an acute care hospital over a five-month period

▶ five most common predictors of violence such as

▶ confusion/cognitive impairment, anxiety, agitation

▶ shouting/demanding, and a history of physical aggression. It also covers staring and eye contact, tone and volume of voice, mumbling, and pacing.

Study Results

- Fifty-six of the 2,063 patients (three percent) were involved in one or more of the violent incidents
- These included 35 episodes of verbal abuse
- 26 physical attack
- 15 threats of physical attack
- 12 incidents where an emergency call went out to security personnel and three cases of sexual harassment

Kim, Ideker, & Todicheeney-Mannes, (2011)

Study 2

- Teo and colleagues (2012)

- Used a retrospective case-control design
- To study whether the level of training is associated with the accuracy of the clinicians' evaluations of violence potential.
- Lack of insight, negative attitudes, active symptoms of major mental illness, impulsivity, unresponsive to treatment.

Study 2: Results ====Teo and colleagues (2012)

❑ They compared the risk assessments that they made at the time patients were admitted to the hospital, to whether or not patients later became physically aggressive toward hospital staff members, such as by hitting, kicking or biting.

❑ At least one violent act during the first 20 weeks after discharge from the hospital was committed by 18.7 percent of the patients studied.

❑ Of the 134 risk factors measured in the hospital, approximately half (70) had a statistically significant occurrence of later violence in the community (p<.05)

Study 3

❖ Almvik and colleagues (2007) based in Norway, conducted a study among the elderly population using the Broset Violence Checklist (BVC).

❑ This study aims to test the validity of the instrument in geriatric settings and to report on the predictive value of an easy-to-use risk assessment instrument.

❑ Assesses confusion, irritability, boisterousness, verbal threats, physical threats and attacks on objects as either present or absent.

❑ It is hypothesized that an individual displaying two or more of these behaviors is more likely to be violent in the next twenty-four hour period.

What was Implemented: Violence Risk Assessment Tool

	Assessment Criteria	Points	Score
V	**Verbal and non-verbal cues** argumentative, uses profanity, loud or very soft voice, verbal threats to do harm to self or others; aggressive stance or other perceived threats	2	
I	**Increased anxiety** hyperactivity, finger drumming, pacing, staring, wringing of hands	2	
O	**Other risk factors** active paranoid delusions, hallucination with negative effect (i.e., command hallucinations), manic state; stopped taking psychiatric medications without prior consultation	2	
L	**Long-term behavior** history of mental illness, violence toward self or others, substance abuse	1	
E	**Excessive alcohol or drug abuse/withdrawal symptoms**	2	
N	**Neurological abnormalities** dementia with behavioral disturbance, delirium	2	
C	**Carries a weapon** or any object for weapon use	2	
E	**Events** recent separation, divorce, death of parent/spouse, child, loss of a job, friend or pet	1	
		TOTAL SCORE	

Instruction: Score each item if criteria is present and total score

No Risk = 0
Low Risk = 1-2
Moderate Risk = 3-5
High Risk = 6 or higher

❑ Do not solely rely on the risk score when determining the appropriate interventions, consider the overall condition in determining risks for violent behavior.

❑ Automatic high risk: a 51/50 or forensic involvement

Risk Assignment---Low Risk

❑ Document score in the medical record.

❑ Search patient and patient's immediate environment for harmful objects, remove potentially dangerous items from room.

❑ As part of the zero tolerance for violence, educate regarding consequences of action.

❑ Notify MD, obtain psychiatric consult.

❑ Offer PRN medications, utilize interventions and reassess every 30 minutes for effectiveness as needed.

❑ Assess privilege level.

De-escalation management per protocol.
• Attempt at verbal de-escalation.
• Maintain a calm appearance, speak in a neutral voice, use simple language.

Assess patient's room assignment and move closer to nurse's station, if possible.
• Place in high visibility room or room with line of sight.
• Ensure to protect patient's privacy.
• Protect patient's physical well-being.

Maintain your safety
• No sudden movements
• Keep distance, allow for exit route
• Buddy up, call security personnel if needed

Moderate Risk

- Document score in the medical record.
- Search patient and patient's immediate environment for harmful objects, remove potentially dangerous items from room.
- Remove patient belonging from the room and place in a secure location.
- Determine, if possible, patient's intent by asking, "Are you angry at anyone? If yes, who?" "Are you thinking about hurting yourself?"
- "Are you thinking about hurting anyone?" "Do you have a plan?"
- ++ Is the patient able to verbally interact with staff?
- Assess for elopement risk.
- Provide actions that will help patient to refrain from hurting self or others, provide sitter/security as needed.
- Assess patient's room and move closer to nurse's station as needed. Place in a high visibility room or room with line of sight.
- De-escalation management protocol.
- Assess patient for assault or suicide ideation, protect patient's well-being. If patient is injured, modify patient's treatment plan as needed.
- Ensure the privacy of the patient.
- Notify MD as needed. Psychiatry evaluation
- Offer PRN medications as needed, reassess for effectiveness every 15 mins. or as needed.

▶ If is ascertained that patient and/or visitor is at risk for violence or if a weapon has been found, the nurse should notify the supervisor and security should be immediately called to the scene.

▶ Security to begin direct observation: "Security Behavior Observation Tool.

▶ RN completes a behavior observation assessment for visual appearance.

▶ A Reporting Responsibility Form (RRF) must be completed to include the following:

▶ (a) Describe the event.

▶ (b) Describe the weapon.

▶ (c) Condition of patient following the event. (d) Signature of nursing personnel writing notes. • A Security Incident Report will be completed.

High Risk

▶ Notify Threat Management Team (TMT) to guide, coordinate, and handle the specific threat at the department or building.

▶ If the patient and/or visitor is determined to be at risk for violence, or if a weapon has been found, the nurse should notify the supervisor and security should be called to the scene immediately.

▶ Contact the Sacramento Sheriff Department if there is a reason to believe the patient is in possession of a weapon.

▶ Security to begin direct observation: "Security Behavior Observation Tool.

▶ RN completes a behavior observation assessment for visual appearance.

A Reporting Responsibility Form (RRF) must be completed to include the following:

(e) Describe the event.

(f) Describe the weapon.

(g) Condition of patient following the event.

(h) Signature of nursing personnel writing notes.

• A Security Incident Report will be completed.

• Debriefing after a violent incident.

• Offer/provide Employee Assistance Program (EAP) for employees involved.

How the Project is being Implemented

▶ The pilot study – 1 West--Med/Surgical/Telemetry unit with a 56-bed capacity.

➢ operates with an average daily census of 38-46 patients

❏ Most of the patients with behavioral disturbances are admitted to this unit. As a result, the incidence of assault and injury to the healthcare workers are at an all-time high.

❏ Although the actual number of incidents were not provided, the nurses and PCTs (patient care technicians) are at a greater risk because they give the most direct patient care.

Stages in the Development and implementation of the Violence Risk Assessment Tool

✓ Gap Analysis/ Literature Review

✓ Presentation to Management

✓ Approval from Management

✓ Presentation to California Nurses Association (CNA)

✓ Approval from CNA

✓ Presentation to the Safety Committee

✓ Approval from the Safety Committee

✓ Presentation to the Nursing Staff

✓ Approval from Nursing Staff

✓ Presentation to the Leadership

At works →

- Implementation of the tool in 1 West (Medical/Surgical/Telemetry) unit.

- Environmental changes, room assignments

- Training of nurses and PCTs, management.

  - Use of the tool, de-escalation methods, self-defense, reporting

- Implementation of the tool hospital wide.

- Inclusion of the tool in the health connect (Epic).

- Flagging- identify violent patients upon readmission

- Implementation of the tool in affiliating hospitals.

- A long road ahead!

- Patience is required!

How it is being Evaluated

- Monthly audits to assess that the nurses actually use the tool, the number of violent patients admitted to the hospital, and the actual number of patients identified by the use of the tool.

- Continuous Quality Improvement (QI) will be performed through

- pre-and post-intervention evaluation,

- staff satisfaction survey in the use of the tool,

- the perception of overall safety by the staff,

- the actual number of patients captured and patient outcomes,

- the actual reduction in staff assault and injury

- inclusion of the staff in making improvements in all aspects of the use of the tool.

- Monthly meetings with the workplace prevention committee will be conducted during the pilot study and beyond.

Lessons Learned

▶ The most important lessons learned from this quality improvement project were drawn from both positive and negative experiences ===

❑ Since the project is far from over, patience and perseverance are keys to the success of this project and future endeavors.

❑ Enacting change is not an easy task so it was important to keep the dialogue and communication open among the workers and all stakeholders.

❑ It is important to never lose sight of the mission that was established at the start of the project, and that is to protect the workforce and to reduce the incidents of violence in the workplace.

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It is important to remember----

❖ Trying to apply project heroics can only lead to failure. It is important to involve colleagues with the same mission who are committed in making a change.

❑ When other people with the same vision were involved, a renewed commitment ensued and better results were seen.

❑ Individual nurses may have little influence over workplace violence but collectively, nurses are poised to influence change, policy, and design to protect healthcare workers.

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Appendix N: The John Hopkin's Evidence-Based Criteria

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

QUALITY of the Evidence
A High Research consistent results with sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence.
Summative reviews well-defined, reproducible search strategies; consistent results with sufficient numbers of well-defined studies; criteria-based evaluation of overall scientific strength and quality of included studies; definitive conclusions.
Organizational well-defined methods using a rigorous approach; consistent results with sufficient sample size; use of reliable **and** valid measures
Expert Opinion expertise is clearly evident

B Good Research reasonably consistent results, sufficient sample size, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence
Summative reviews reasonably thorough and appropriate search; reasonably consistent results with sufficient numbers of well-defined studies; evaluation of strengths and limitations of included studies; fairly definitive conclusions.
Organizational Well-defined methods; reasonably consistent results with sufficient numbers; use of **reliable and valid** measures; reasonably consistent recommendations
Expert Opinion expertise appears to be credible.

C Low quality or major flaws
Research little evidence with inconsistent results, insufficient sample size, conclusions cannot be drawn
Summative reviews undefined, poorly defined, or limited search strategies; insufficient evidence with inconsistent results; conclusions cannot be drawn
Organizational Undefined, **or** poorly defined methods; insufficient sample size; inconsistent results; undefined, poorly defined or measures that lack adequate reliability or validity
Expert Opinion expertise is not discernable or is dubious.
A study rated an A would be of high quality, whereas, a study rated a C would have major flaws that raise serious questions about the believability of the findings and should be automatically eliminated from consideration.

Newhouse R, Dearholt S, Poe S, Pugh LC, White K. The Johns Hopkins Nursing Evidence-based Practice Rating Scale. 2005. Baltimore, MD,
              The Johns Hopkins Hospital; Johns Hopkins University School of Nursing.

Appendix O: Review of Articles and Evaluation

Author, Date, and Title	Strength of Evidence and Evidence Type	Background	Limitations	Results
Kim, Ideker, & Todicheeney-Mannes (2011). Usefulness of aggressive behaviour risk assessment tool for prospectively identifying violent patients	**Level 1, rated "B**". A prospective cohort design which supports the same finding in different samples of the same population.	The ten-point Aggressive Behavior Assessment tool (ABRAT) was completed within 24 hours of admission using the five most common predictors of violence such as confusion/cognitive impairment, anxiety, agitation, shouting/demanding, and a history of physical aggression. It also covers staring and eye contact, tone and volume of voice, mumbling, and pacing.	A disadvantage of prospective cohort studies is that patient consent is generally required, which can lead to selection bias or a bias commonly known as the Hawthorne effect. The Hawthorne effect occurs when people who know that they are being observed (such as during a research study) temporarily change their behavior or performance so although the sample size was large, the sample only included English-speaking patients.	According to the study, using a specially designed risk assessment tool within 24 hours of admission was an effective way of identifying which hospital patients in the medical and surgical units would become violent.

Monahan, J., Steadman, M., Robbins, P., Siver, E. (2005). The MacArthur violence risk assessment study.	A level 3 but rated "A" with a mean standard deviation reported as significant at $p<0.5$, with n= 1136.	Study to develop violence risk assessment software, and also validated that software on independent samples of patients. Personal factors (e.g., demographic and personality variables), historical factors (e.g., past violence and mental disorder), contextual factors (e.g., social support and social networks), and clinical factors (e.g., diagnosis and specific symptoms) were assessed.	The sample selected were English-speaking patients only between the ages of 18 and 40, who were of White, African American, or Hispanic ethnicity, and who had a chart diagnosis of thought or affective disorder, substance abuse, or personality disorder with a median length of stay of nine days.	Although this tool is used to ascertain the occurrence and details of a violent incident in the community, the results of this validation study is highly accurate when compared to other approaches to assessing risk among people hospitalized in acute-care psychiatric facilities and may be integrated in the hospital setting.
Kling, R., Corbiere, M., Milord, R., Yassi, A., Morrison, J., Craib, K., ... Long, V. (2006). Use of a violence risk assessment tool in an acute care hospital.	Level 3, rated "B". Level 3 articles are the least valuable because they are explorative and use secondary data, and/or do not produce a summary statistic	Alert system protocol mandates initial assessment of all patients on admission to the hospital using the M55a form. If a patient displays certain risk factors for aggression or violence, a flagging system (an alert) is implemented. This process involves placing a "V" notation in the computerized Patient Care Information System and on the patient's chart and wristband. Patients are periodically reassessed using the M55a form. If no risk factors are observed when the patient is reassessed with the M55a form, the flag is removed.	Overall use of the Alert assessment form for violent and non-violent patients was 75.7% and 35.4%, respectively. The assessment form was found to have moderate sensitivity (71%) and high specificity (94%).	It is reasonably effective in identifying potentially violent or aggressive patients when it is used according to protocol.

Teo, A. R., Holley, S. R., Leary, M., & McNiel, D. (2012). The relationship between level of training and accuracy of violence risk assessment.	Level 1, rated "B" The study used a retrospective case-control design to study whether the level of training is associated with the accuracy of the clinicians' evaluations of violence potential.	Clinicians checked for attributes that covered areas such as lack of insight, negative attitudes, active symptoms of major mental illness, impulsivity, unresponsive to treatment. They compared the risk assessments that they made at the time patients were admitted to the hospital, to whether or not patients later became physically aggressive toward hospital staff members, such as by hitting, kicking or biting.	In the United States, structured tools such as the HCR-20-C are only beginning to be used in hospitals. HCR-20-C scale is used to evaluate a patient's risk for violent behavior so training is needed for its use.	The studies all reported efficacy in determining the incidence of violence in patients during their hospital stay.
Almvik, R., Woods, P., & Rasmussen, K. (2007) Assessing for imminent violence in the elderly: the brost violence	**Level 3, rated "B".** Level 3 articles are the least valuable because they are explorative, use secondary data, and/or do not produce a summary statistic.	This tool was used to assess behaviors such as confusion, irritability, boisterousness, verbal threats, physical threats, and attacks on objects as either present or absent.	It is based on hypothesis that an individual displaying two or more of these behaviors is more likely to be violent in the next twenty-four hour period.	This study disclosed that patients in geriatric wards and residents in nursing homes who are aggressive have higher BVC scores than the non-violent subjects indicating that the BVC does predict violent episodes in these settings.

Yang, M., & Wong, S. (2010). The efficacy of violence prediction: a meta-analytic comparison of nine risk assessment tools	**Level 1, rated "A"** A meta-analyses study of the effect sizes of nine commonly used risk assessment tools and their subscales. This study used a within-subject design to improve statistical power and multilevel regression models to disentangle random effects of variation between studies and tools and to adjust for study features	Assessed the predictive accuracy of more than one tool	Efforts to improve the tool are warranted, as is evaluation of its benefit in settings with low prevalence of violence. Also, greater effort must be taken to prevent violence once an aggressive patient has been identified.	If the intention is only to predict future violence, then the 9 tools are essentially interchangeable; Based on the studies and the testimonials of the professionals who have used it, the use of a behavioral risk assessment tool proves to be an effective tool in reducing the incidence of violence in the healthcare setting

Appendix P: DNP Project Approval Form

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DNP Project Approval Form: Statement of Determination

Student Name: Mira Aidasani-Diwata _____

Title of Project: Use of a violence assessment tool to predict aggressive behavior in patients admitted to the hospital.

Brief Description of Project:

A) Aim Statement:
The aim is to develop and implement a macro system process for identifying and managing patients who exhibit aggressive or violent behavior, thereby potentially reducing the incidence of violence, abuse, harassment, and aggression towards healthcare staff and bystanders.

B) Description of Intervention:

The implementation of a violence risk assessment tool to predict aggression or violent tendencies in newly admitted patients; this will lead to the creation of a process to manage aggressive patients. The tool will be implemented in medical and surgical units, with plans to be implemented hospital wide, and in the northern California region of Kaiser Permanente

C) How will this intervention change practice?

The management of patients presenting with violent and aggressive behaviors is critical in the safety of the patients, the staff, other patients in the area, and bystanders. Currently, there is no violence risk assessment tool being used at Kaiser hospital. The tool will assist in identifying patients with behavioral disturbances and in providing effective interventions. Expectantly, this intervention will also examine existing treatment guidelines, if any, in dealing with aggressive patients. This intervention also reflects the statement policy of zero tolerance for workplace violence. In addition, a self-training module already used in ED will be adopted for staff training in the inpatient units. The use of the module will aim to increase awareness and skills in early recognition of, and effective response to aggressive behavior of patients in the hospital.

D) Outcome measurements: Evaluate the effectiveness of a violence risk assessment tool in predicting violent tendencies through continuous quality improvement (CQI); measure the positive and the negative effect, staff feedback, decrease in the number of staff injury, success stories, predictive efficacy, and inter-rater reliability.

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To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *
Instructions: Answer YES or NO to each of the following statements:

Project Title: **Implementation Of A Violence Risk Assessment Tool in a Hospital**	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	x	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	x	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Mira Aidasani-Diwata

Signature of Student: _Mdiw75_   DATE 5-1-205

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):
Amy Nichols

Signature of Supervising Faculty Member (Chair): _Nichols_   DATE 5-1-205