Implementation of a Violence Checklist to Reduce Seclusion/Restraint on Inpatient Psychiatry

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Abstract

Problem & Purpose: The effective management of patient aggression and violence presents a significant challenge to inpatient psychiatry units, with seclusion and restraint (S&R) commonly utilized to manage these crisis situations. The purpose of this quality improvement (QI) project is to implement an aggression/violence screening tool on an adult acute psychiatry unit to promote the early identification and management of potential for patient aggression/violence.

Methods: The Brøset Violence Checklist (BVC) is an aggression/violence screening tool that assesses for six objective risk factors to establish the potential risk for patient aggression/violence. Aggression is defined as behavior carried out with the intent to harm another person, while violence is an extreme form of aggression that has severe harm (i.e. physical injury or death) as the end goal (Allen & Anderson, 2017). Staff nurses on a 15-bed high acuity inpatient psychiatry unit were trained on the use of the BVC and the least restrictive interventions to implement when a patient has been identified as at risk for aggression/violence. The BVC was to be completed on each patient admission on the unit over a 10-week period. Pre and post implementation surveys were conducted to assess the perception of staff nurses on their knowledge and skill set in the effective management of aggression/violence.

Results: During the implementation period, the project leader provided training to 100% of staff nurses (n=43) under the adult inpatient psychiatry service on the use of the BVC to assess for early manifestations of risk for aggression/violence. Staff nurses screened 43% (n=38) of new patient admissions during the project implementation period. Staff nurses reported feeling that a screening tool would be useful in assessing for patient aggression/violence both pre and post implementation.

Conclusion: Aggression/violence screening tools are an essential component in the effective management of patient aggression/violence and reducing S&R on inpatient psychiatry. While this QI project was successful in implementing the BVC to aid in the early assessment of patients at risk for aggression/violence, future QI projects should assess the role that least restrictive interventions play in reducing patient aggression and S&R events.

Introduction

The effective management of patient aggression and violence presents a significant challenge to inpatient psychiatry staff, with seclusion and restraint (S&R) frequently utilized to manage these crisis situations (Blair et al., 2017). Aggression is defined as behavior carried out with the intent to harm another person, while violence is an extreme form of aggression that has severe harm (i.e. physical injury or death) as the end goal (Allen & Anderson, 2017). Approximately 1 in 5 patients admitted to an inpatient psychiatric unit may commit an act of aggression/violence (Iozzino, Ferrari, Large, Nielssen, & de Girolamo, 2015). Moreover, between 75% and 100% of nursing staff on inpatient psychiatry units have reported being assaulted by a patient at some stage in their careers (Iozzino, Ferrari, Large, Nielssen, & de Girolamo, 2015). Similarly, the emotional effects of exposure to physical violence on inpatient units include anger, shock, fear, depression, anxiety, and sleep disturbance (Iozzino, Ferrari, Large, Nielssen, & de Girolamo, 2015). The aim of S&R is to restore the safety of the milieu; however, there are often serious consequences associated with the use of S&R. In the late 1990s, the Joint Commission issued a “zero tolerance” policy for deaths related to restraint usage in response to an increase in restraint related deaths. (Joint Commission on Accreditation of HealthCare Organizations [JCAHO], 1999). Moreover, the root cause analysis of these events revealed that inconsistent patient assessment, inadequate care planning, and insufficient staff

orientation and training were frequently correlated with these sentinel events (JCAHO, 1999). Nearly twenty years later, evidence still supports that staff training and early identification of potential aggression are essential components in reducing the usage of S&R (see Appendix A). Nonetheless, a psychiatric unit at large academic hospital in the mid-atlantic region, continues to struggle with high rates of S&R, complicated by inconsistent staff training on the utilization and indications of S&R. The purpose of this project was to implement use of the Brøset Violence Checklist (BVC) on an adult acute psychiatry unit to aid in the early identification and management of potentially aggressive/violent patients (see Appendix B).

Literature Review

The literature review will critically appraise the current literature available to evaluate the most effective interventions in reducing S&R events related to patient aggression/violence on adult inpatient psychiatry units. Furthermore, the review will provide an understanding of the BVC as a promising intervention for the reduction of patient aggression/violence and S&R events. Five articles were selected to appraise the literature, describe what is known, reveal gaps in knowledge, and establish recommendations for practice.

The five articles reviewed included, two quasi-experimental studies, two systematic reviews, and one narrative review. All studies in the literature review aimed to either develop or examine interventions effective in reducing S&R. Researchers on two different quasi-experimental studies found that enhanced staff training and aggression screening tools were successful in reducing S&R events on adult inpatient psychiatry units (Blair et al., 2017; Jayaram, Samuel, & Konrad, 2012). Similarly, researchers on two systematic reviews and one narrative review all identified enhanced staff training as an effective intervention in reducing the use of S&R in response to patient aggression (Goulet, Larue, & Dumais, 2017; Scanlan, 2010;

Wilson, Rouse, Rae, Jones, & Kar Ray, 2015). Goulet, Larue, & Dumais (2017) also supported the utilization of aggression/violence screening tools as an effective intervention in S&R reduction programs on adult inpatient psychiatry units. Likewise, Wilson, Rouse, Rae, Jones, & Kar Ray (2015) revealed proactive care (early patient assessment and treatment planning) as a common element amongst S&R reduction programs. Strong organizational leadership and S&R debriefing were also shown to have efficacy in reducing S&R events (Goulet, Larue, & Dumais, 2017; Scanlan, 2010; Wilson, Rouse, Rae, Jones, & Kar Ray, 2015). The current literature in reducing aggression/violence and S&R events supports multifaceted interventions grounded in strong leadership, staff training, early assessment via the use of aggression/violence screening tools, and debriefing of S&R events. This data provides a foundation for organizations and professionals to develop interventions grounded in evidence-based practice with the purpose of improving outcomes for one of healthcare's most vulnerable populations.

Theoretical Framework

Kurt Lewin's change theory was used to guide the implementation of the BVC on the adult acute psychiatry unit. Lewin's change theory was derived from his numerous published works on change process and human behavior as a social scientist in the 1930s and 1940s (Hussain et al, 2018). Lewin's change theory encompasses three distinct stages that guide the process of organizational change: unfreezing, change, and refreezing (Hussain et al., 2018). Lewin's change theory aims to identify and overcome barriers to change, while simultaneously acknowledging the roles of human behavior and organizational culture in change.

The first stage of Lewin's change theory, unfreezing, recognizes that organizational change is often a process fraught with resistance from employees accustomed to the status quo. Unfreezing involves developing and implementing strategies that support letting go of the status

quo, while concurrently facilitating “buy-in” for change. Unfreezing involves assuring that champions for change outweigh the expected resistance to change (Hussain et al., 2018). The adult acute psychiatry unit has already begun the process of unfreezing through implementing new leadership roles dedicated to the implementation of evidence-based practice to guide unit policy and procedures. This stage of change involves engaging stakeholders such as leadership, administration, and unit staff on the necessity of establishing evidence-based interventions to manage patient aggression/violence. Unfreezing requires special attention to lessoning the barriers to implementation and sustainability.

The second stage, change, involves implementation of the BVC and organizational engagement in the change process. The change process can only begin once team support and champions are well established from the work done during the unfreezing stage (Hussain et al., 2018). The implementation of the BVC will include staff education on the tool, regular huddles with leadership and staff to support morale, measurement and evaluation of nursing staff use of the BVC on new patient admissions, and the development of a plan for sustainability.

Sustainability is the foundation of the third stage of Lewin’s change theory, refreezing. Refreezing involves the organization constantly reevaluating and maintaining change (Hussain et al., 2018). Refreezing assures that effective change is not fleeting, but permanent. Refreezing in the implementation of the BVC involves ongoing engagement with leadership and staff, as well as tracking, evaluating, and disseminating staff nurses’ use of the tool and its impact on identifying patients at risk for aggression/violence.

Methods

This QI project was implemented over a 10-week period and aimed to improve the assessment and management of patient aggression/violence on an adult acute inpatient psychiatry unit through the implementation of the BVC. The unit is one of four behavioral health units at a large academic hospital. The adult acute inpatient psychiatry unit is a 15-bed unit for individuals 18 and older, treating acute conditions including, schizophrenia, schizoaffective disorder, bipolar mania, depression with psychotic features, peripartum psychosis, aggression and violence, suicidal ideations, homicidal ideations, and not otherwise specified psychosis. Finally, the inclusion criterion included all admissions to the adult acute inpatient psychiatry unit, exclusion criterion excluded children and adolescents, and any patient not admitted to the adult acute inpatient psychiatry unit.

A project description was submitted to the Institutional Review Board (IRB) at the University of Maryland, Baltimore (UMB) and the organization of implementation and determined to be non-human subject research. To protect human subjects, patient information was deidentified for data collection and analysis. There are no identifiable ethical risks associated with the use of the BVC for staff nurses or patients, the BVC is an objective tool that does not require extensive assessment or history taking, and does not add excessive burden to the workload of staff nurses.

The project leader trained staff nurses (n=43) on the use of the BVC and the least restrictive interventions to implement when a risk for aggression/violence had been identified. Training included on-site educational huddles over a two-week period, and an online interactive training bundle including educational tools by the creator of the BVC. Nurses were expected to

complete the BVC on each patient admission on the adult acute psychiatry unit, and the document became a part of patient admission paperwork.

The adult acute psychiatry unit secretary kept track of all patient admissions on the unit. The BVC was included in the unit admission packets during patient intake, and then stored in a "BVC" binder, this allowed for simple comparison of total unit admissions and admissions with a completed BVC. Additionally, the project leader used an audit tool to conduct weekly chart audits, tracking the number of completed BVCs on admission, the identified risk of each admission, as well as if there were any S&R events on the unit (see Appendix C). The project leader also completed a run chart for each month of the implementation period utilizing the data collected from the audit tool. Run charts compared the date of admission to the percentage of admissions with completed BVCs, which allowed for tracking of implementation goal attainment.

Results

Current literature supports that use of aggression/violence screening tools are an essential component in interventions aimed at reducing patient aggression/violence on inpatient psychiatry units. Prior to the implementation of the BVC, the adult acute psychiatry unit had no standard tool in practice to assess for patient risk for aggression/violence. Assessment of aggression/violence on the unit was often based on the individual nurse's skill set, leading to inconsistent outcomes, underutilization of least restrictive interventions, and missed opportunities to avoid seclusion and restraint events.

The successful implementation of the BVC and its sustainability were dependent upon both structural and process changes on the unit. The structural changes necessary for the implementation of the BVC included changes in staff nurse skill set via training on identifying

potential risk factors for patient aggression/violence through the use of the BVC. Process changes included staff nurses actually utilizing the BVC on every patient admission, and establishing the most appropriate interventions to reduce seclusion and restraint related to patient aggression/violence.

During the implementation period of the BVC, 100% of staff nurses (n= 43) under the adult inpatient psychiatry service received training on the use of the BVC to assess for the early manifestations of potential for patient aggression/violence either on-site or via online educational training. Staff nurses compliance with the BVC fluctuated throughout the implementation period, and the goal of 100% compliance was not consistently met. There were 91 patient admissions during the implementation period. Staff nurses screened 43% (n =38) of patient admissions during the implementation period, with the final month of implementation, December, having the highest percentage of nursing compliance at 45% (n=12). Barriers to implementation include the BVC being assessed on paper, which complicated the storage and accessibility of the BVC, as most patient assessments are stored in the electronic health record (EHR). Facilitators include the simplicity of the BVC, the BVC is a quick and objective screening tool that did not add an additional burden to an already heavy work flow on the unit. Similarly, staff nurses reported feeling that an aggression/violence screening tool would be useful in assessing for aggression/violence both pre and post implementation.

Discussion

Unit leadership and staff nurses alike agreed that an aggression/violence screening tool is a necessary component in the effective management of patient aggression/violence. Furthermore, 100% of staff nurses (n=43) received training on the BVC during the implementation period via online training resources and onsite training huddles. Over the 10-week implementation period

staff nurses screened 43% (n=38) of patient admissions using the BVC, with several days achieving 100% compliance. However, upon implementation, it was realized that 100% compliance was an overly ambitious goal for a new intervention that had such a small implementation period. Nonetheless, compliance continued to increase throughout the 10-week implementation period, with December, the final month of implementation, achieving an average compliance of 45% (n=12). A longer implementation period would be required to assess the impact of the BVC on reducing seclusion and restraint events related to patient aggression/violence. Previous studies have been implemented over a 2-year period or included over 200 consecutive admissions, compared to the sample of 91 admissions over a 10-week period for this quality improvement project (Blair et al., 2017; Jayaram, Samuel, & Konrad, 2012)

Limitations to compliance include the BVC being assessed on paper versus the EHR; thus, complicating the accessibility and storage of the BVC. To promote the sustainability of the BVC, the tool should be adapted into the EHR making it readily accessible for staff nurses to complete. Similarly, unit leadership support the necessity of implementing an aggression/violence screening tool on the unit and are currently in discussions about purchasing a new EHR specific to the assessment requirements of inpatient psychiatry.

Conclusions

The effective management of aggression/violence is essential to maintaining the safety of both patients and staff on inpatient psychiatry units. These results support that aggression/violence screening tools have the potential to promote the early identification of patients at risk for aggression/violence on inpatient psychiatry units. Future QI projects should expand upon this project to determine if early assessment actually leads to early intervention, and

if so do these interventions reduce patient aggression/violence and S&R events.

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Appendix A

Evidence Review Table

Author, Year	Study objective(s)/Intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level/ Quality Rating
Blair et al., 2017	To evaluate the effectiveness of a safety initiative (including The Broset Violence /Aggression Checklist, mandated staff education, and increased frequency of assessment) designed to reduce the incidence of seclusion and restraint.	Quasi-experimental study/Pretest-Posttest Design	Admissions at a 120-bed psychiatric service at a large urban hospital.	Reduction in seclusion rates over a two-year period as measured by pretest and posttest analysis of incidence and duration of S&R events.	The intervention was associated with a 52% reduction in the rate of seclusion events ($p< 0.01$). Moreover, duration of seclusion events was reduced by 27%. The study supports routine assessment for potential violence/ aggression, increased staff presence, and enhanced staff training.	3 B
Goulet, Larue, & Dumais (2017)	To examine the effectiveness of S&R reduction programs	Systematic Review	23 studies including randomized controlled trials (RCTs), quasi-experimental	To analyze the effectiveness of S&R reduction programs, as measured	Six key components for reducing S&R events were identified amongst studies: - Strong	5 B

			studies, pretest/posttest studies, and qualitative studies examining the effectiveness of S&R reduction programs.	by a decrease in frequency and duration of S&R events.	Leadership -Staff Training -Post seclusion and restraint review -Patient involvement -Prevention tools -Therapeutic environment The two RCTs in the systematic review showed statistically significant reduction in S&R events (p=.004; p=.001) (Bowers et al., 2015; Putkonen et al., 2013) Nearly every study analyzed in the systematic review showed a reduction in S&R events, though not all reductions were statistically significant. Evidence supports that S&R reduction programs are useful in	

					reducing the frequency and duration of S&R.	
Iozzino, Ferrari, Large, Nielssen, & de Girolamo (2015)	To evaluate the prevalence and risk factors of violence on inpatient psychiatry units.	Systematic Review and Meta-Analysis	23,972 patients across 35 studies conducted between 1995 and 2014.	The prevalence and risk factors associated with violence on inpatient psychiatry units, as measured by the pooled rate of violence in published studies.	At least 17% of patients in the systematic review committed at least one act of violence. Patients with increased risk for violence included male patients, involuntary patients, patients with schizophrenia, and patients with alcohol use disorder.	5A
Jayaram, Samuel, & Konrad (2012)	To develop and evaluate an aggression management tool (The Phipps Aggression Screening Tool) on an inpatient psychiatry unit with the objectives of early identification of potentially aggressive patients, and enhancing staff training and skill set.	Quasi-experimental/Pretest-Posttest Design	229 consecutive admissions on an inpatient psychiatry unit.	Reduction in S&R over a year period as measured by pre and posttest analysis of frequency and duration of S&R events.	With the implementation of The Phipps Aggression Tool seclusion rates decreased from 32% to 22.4% over a year period. Results also support the significance of early assessment and staff training in reducing S&R events.	3 B
Wilson, Rouse, Rae, Jones, &	To examine the interventions available for reducing restraint	Systematic Review	60 qualitative studies on interventions used to	To determine what interventio	Five common intervention strategies	5 A

Kar Ray (2015)	usage in mental healthcare settings.		reduce restraint events.	ns are successful in reducing restraint events, as measured by pre and posttest analysis of restraint frequency and duration.	across studies were revealed: -Proactive care (i.e. staff training and assessment/ planning strategies) -Organization Development (i.e. staff ratios and strong leadership) -Empowerment (i.e. open forums for staff concerns, and increased patient involvement in treatment planning) -Relationships/ Communicatio n (i.e. open communication between patients, staff, and leadership) -Reviewing practice (i.e. use of restraint data and debriefing).	

Rating System for Hierarchy of Evidence

Level of the Evidence	Type of the Evidence
I (1)	Evidence from systematic review, meta-analysis of randomized controlled trails (RCTs), or practice-guidelines based on systematic review of RCTs.
II (2)	Evidence obtained from well-designed RCT
III (3)	Evidence obtained from well-designed controlled trials without randomization
IV (4)	Evidence from well-designed case-control and cohort studies
V (5)	Evidence from systematic reviews of descriptive and qualitative studies
VI (6)	Evidence from a single descriptive or qualitative study
VII (7)	Evidence from the opinion of authorities and/or reports of expert committee

Melnyk, B.M. & Fineout-Overholt, E. (2014). *Evidence-based practice in nursing & healthcare: A guide to best practice* (3rd ed.). New York: Lippincott, Williams & Wilkins.

Rating Scale for Quality of Evidence

A: High – consistent results with sufficient sample, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific literature

B: Good – reasonably consistent results; sufficient sample, some control, with fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C: Low/major flaw – Little evidence with inconsistent results; insufficient sample size; conclusions cannot be drawn

Newhouse, R.P. (2006). Examining the support for evidence-based nursing practice. *Journal of Nursing Administration, 36*(7-8), 337-40.

Appendix B

Brøset Violence Checklist

The Brøset Violence Checklist (BVC©) - quick instructions: Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well know client normally is confused (has been so for a long time) this will give a score of 0. If an increase in confusion is observed this gives a score of 1.

Patient/Client data:

	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

The Brøset Violence Checklist Interpretation and Operationalisation

Interpretation of scoring:

Score = 0 Score = 1-2 Score > 2

The risk of violence is small
The risk of violence is moderate. Preventive measures should be taken.

The risk of violence is very high. Preventive measures should be taken
In addition, a plan should be developed to manage the potential violence.

Operationalisation of behaviours/items:

Confused	Appears obviously confused and disorientated. May be unaware of time, place or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.
Physically threatening	Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another persons clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Verbally threatening	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking Objects	An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.

NB: For the behaviours/items physically threatening, verbally threatening and attacking objects the operationalisation was adapted from the Behavioural Status Index (Reed, Woods & Robinson, 2000) by one of the authors (Woods).

Appendix C

Audit Tool

Day Shift: Date of Admission	De-identified Patient ID	Brøset Violence Checklist Completed on Admission Yes = 1; No = 2	Risk for Violence/Aggression Identified Yes = 3; No = 4	Seclusion/Restraint Event During Hospitalization Yes = 5; No = 6
Night Shift: Date of Admission	De-identified Patient ID	Brøset Violence Checklist Completed on Admission Yes =1; No=2	Risk for Violence/Aggression Identified Yes = 3; No = 4	Seclusion/Restraint Event During Hospitalization Yes = 5; No = 6

Appendix D

Permission to Use

Permission to utilize The Brøset Violence Checklist (BVC) received from developer Dr. Roger Almvik at info@riskassessment.no.