Background: Violence & Aggression

- ED Violence Survey Study
- Mental Health Hospitals
- NCHA/NCNA Survey
- NCQC PSO Submitted Events
ED: Reporting Workplace Violence

<table>
<thead>
<tr>
<th>Did NOT report</th>
<th>Did notify:</th>
<th>Physical Violence</th>
<th>Verbal Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Security</td>
<td>65.7%</td>
<td>44.9%</td>
</tr>
<tr>
<td></td>
<td>Immediate Supervisor</td>
<td>64.2%</td>
<td>45.4%</td>
</tr>
<tr>
<td></td>
<td>Other ED Nurses</td>
<td>63.2%</td>
<td>58.1%</td>
</tr>
<tr>
<td></td>
<td>ED Physician</td>
<td>54.6%</td>
<td>37.9%</td>
</tr>
</tbody>
</table>


ED Violence Study: Reporting

What contributes to underreporting of violence among ED nurses?

1. A perception that assaults are part of the job
2. An employee belief that reporting will not benefit them
3. Assaults may be viewed as evidence of poor performance
4. Lack of institutional policies
## Workplace Violence Experienced by ED Nurses

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>% of ED Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grabbed/Pulled</td>
<td>48%</td>
</tr>
<tr>
<td>Hit/slapped/punched</td>
<td>41%</td>
</tr>
<tr>
<td>Spit on</td>
<td>36%</td>
</tr>
<tr>
<td>Pushed/shoved/thrown</td>
<td>28%</td>
</tr>
<tr>
<td>Kicked</td>
<td>26%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verbal Abuse</th>
<th>% of ED Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sworn/cursed at</td>
<td>89%</td>
</tr>
<tr>
<td>Yelled/shouted at</td>
<td>89%</td>
</tr>
<tr>
<td>Called names</td>
<td>68%</td>
</tr>
<tr>
<td>Threatened with legal action</td>
<td>52%</td>
</tr>
</tbody>
</table>


## ED Patient Characteristics & Activities

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>% of ED Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the influence of alcohol</td>
<td>56%</td>
</tr>
<tr>
<td>Under the influence of drugs (illicit/prescription)</td>
<td>47%</td>
</tr>
<tr>
<td>Psychiatric patient</td>
<td>45%</td>
</tr>
</tbody>
</table>

### Activities Where Violence Occurs

<table>
<thead>
<tr>
<th>Activities Where Violence Occurs</th>
<th>% of ED Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triaging patient</td>
<td>40%</td>
</tr>
<tr>
<td>Restraining/subduing</td>
<td>35%</td>
</tr>
<tr>
<td>Performing a procedure</td>
<td>29%</td>
</tr>
</tbody>
</table>
Psychiatric Hospitals

CA DMH State Forensic Patient Population:
- 1997 – 62%
- 2010 – 90%

Staff assaults (2007-2010) increased 18%
- Psychiatric Technicians – 30%
- RN’s – 52%

CA DMH Citations

1. Employees were not provided with effective training and instruction
2. The employer did not conduct effective inspections and evaluations of physical assault hazards
3. Facility did not maintain effective Injury and Illness Prevention Program (Program)
   - procedures did not provide for communication to the employees the history and behavioral triggers of the hundreds of unsupervised individuals that they were expected to confront.

$110 K in fines
### Clinical Decision Making: Effective Risk Assessment

- 18% of civilly committed patients assault others
- 30-35% engage in fear-inducing behavior
- 66% of patients who are a danger to others are likely to engage in some type of violence within 72 hours of admission
- Small clusters of patients are typically involved in a large number of violent incidents

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### VA- Behavioral Threat Management Program

#### Program Goals

1. Facility preparedness
2. Successful interaction during first few minutes
3. Improved control of patient’s behavior
4. Delivery of better & more complete medical care

#### Prevention & Management of Disruptive Behavior Curriculum

1. General knowledge
2. Personal safety skills ("break away" skills)
3. De-escalation skills
4. Therapeutic containment for out of control patients
**VA- Behavioral Threat Management**

<table>
<thead>
<tr>
<th>Session</th>
<th>Knowledge</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakaway</td>
<td>Criminal law &amp; reasonable force</td>
<td>Confidence in actions</td>
</tr>
<tr>
<td></td>
<td>Body language/ personal space</td>
<td>Manage physical ‘messages’</td>
</tr>
<tr>
<td></td>
<td>Defensive body positioning</td>
<td>Remain stable and responsive</td>
</tr>
<tr>
<td></td>
<td>Escape and evade</td>
<td>Using physical environment</td>
</tr>
<tr>
<td></td>
<td>Distraction for escape</td>
<td>Prevention for quick exit</td>
</tr>
<tr>
<td></td>
<td>Defence against wrist/body holds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defence against punches and kicks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defence against knee to groin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defence against strangulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defence against head butts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defence from attacks from the rear</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defence from animals</td>
<td></td>
</tr>
</tbody>
</table>

Participants will be reminded that physical breakaway techniques are to be used as a last resort and the emphasis should always be to calm the situation through effective communication skills. It is always better to disengage prior to crisis.

**NC Nursing Survey on Workplace Violence: Respondents**

426 NCNA nurses
- Direct Care (62%)
- Nurse Supervisor/management (27%)
- Other (11%)

Represented
- Inpatient unit (incl. Behavioral Hlth) (51%)
- ED or Primary Care/Outpatient (35%)
### Assault in the ED

- Respondents reported witnessing assaults and attempts during the past month (29%)
- ED respondents witnessed a higher percentage of assaults and attempts during the past month (58%)
- ED nurses also reported greater likelihood of receiving training, needed medical treatment, counseling and time off

### What Would Reduce Violence?

1. Provide more training (de-escalation, situational awareness)
2. Greater security guard presence (...but number 1 response among direct care RN)
3. Technology: panic buttons, metal detectors
4. Hold visitors & patients accountable, laws enabling prosecution
5. Increase staffing & improve planning (direct care RN)
Assault Support

Direct Care RN responses:

How many agreed or strongly agreed that they...

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were prepared to mitigate assault</td>
<td>51%</td>
</tr>
<tr>
<td>Received strong support from employer after the assault</td>
<td>40%</td>
</tr>
<tr>
<td>Felt protected from further assault</td>
<td>26%</td>
</tr>
<tr>
<td>Received needed medical care</td>
<td>53%</td>
</tr>
<tr>
<td>Received follow-up and/or counseling</td>
<td>25%</td>
</tr>
</tbody>
</table>

NCNA Survey: Policies

After an assault did you or someone on your behalf notify supervisor?  
Direct Care Nurse: 67% Yes

After an assault did the affected employee notify their supervisor?  
Nurse supervisor: 96% Yes

Does your employer/facility have a policy for treatment post assault?  
67% Yes

Training is not offered on identification, prevention and management of violence or is offered no more frequently than “every 5-10 years.”  
22% Yes
NCQC PSO Database

Type of Violence/Aggression & Harm

Type of Violence/Aggression Event
Reported to NCQC PSO
January 2012-June 2015

- Patient-to-Patient: 15%
- Patient-to-Staff: 20%
- Self-inflicted: 65%
- Staff-to-Patient: 0%

AHRQ Harm Scale
All Violence/Aggression Events
Reported to NCQC PSO
January 2012-June 2015

- No harm: 16%
- Mild harm: 52%
- Moderate harm: 32%
Potential Causes of Violence & Aggression

- **Internal factors**
  - Previous aggressive/violent behaviors
  - Mental or physical conditions
- **External factors**
  - Environmental factors
  - Medication side effects
- **Situational/interactional factors**
  - Incongruent organizational systems and actions
  - Care team characteristics
Contributing Factors to Violence & Aggression

Potential Contributing Factors to Violence/Aggression Events Reported to NCQC PSO
January 2012-June 2015

- Environmental Factors
- Patient Factors
- Process Factors
- Staff Factors

Reported Contributing Factors
• Culture of safety, management
• Staff training
• Presence of policies
• Clarity of policies
• Communication among team
• Human Factors: Stress

History of Violence/Aggression

Reported History of Violence/Aggression for All Violence/Aggression Events Reported to NCQC PSO
January 2012-June 2015

- 1 prior episode
- Multiple prior episodes
- No prior episodes
- Subsequent episodes
- Not Reported
It is difficult to prevent patients from becoming aggressive

<table>
<thead>
<tr>
<th>Psychiatric Nurse Response</th>
<th>Psychiatric Facility Staff vs Behavioral Health Patients Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
</tr>
<tr>
<td>Agree/Totally Agree</td>
<td></td>
</tr>
<tr>
<td>Disagree/Totally Disagree</td>
<td></td>
</tr>
<tr>
<td>No Response</td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td></td>
</tr>
</tbody>
</table>

1 Bock TM (2011) Masters Thesis, Stellenbosch University, South Africa

Patients are aggressive because they are ill

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<tr>
<td>Disagree/Totally Disagree</td>
<td></td>
</tr>
<tr>
<td>No Response</td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td></td>
</tr>
</tbody>
</table>

1 Bock TM (2011) Masters Thesis, Stellenbosch University, South Africa
Patients are aggressive because of the environment they are in

Psychiatric Nurse Response

Psychiatric Facility Staff vs Behavioral Health Patients Response

2005 vs 2013

Agree
Disagree
No Response

Behavioral Health Patients

Agree
Unsure

Psychiatric Facility Staff

Agree
Disagree

1 Bock TM (2011) Masters Thesis, Stellenbosch University, South Africa

Patients commonly become aggressive because [of perception that] staff do not listen to them

Psychiatric Nurse Response

Psychiatric Facility Staff vs Behavioral Health Patients Response

2005 vs 2013

Agree
Disagree
No Response

Behavioral Health Patients

Agree
Disagree

1 Bock TM (2011) Masters Thesis, Stellenbosch University, South Africa
Poor communication between staff and patients leads to patient aggression

Psychiatric Nurse Response

Psychiatric Facility Staff vs Behavioral Health Patients Response

2005 | 2013
--- | ---
Psychiatric Facility Staff
Agree | Agree
Disagree | Agree
Behavioral Health Patients
Agree | Agree

Psychiatric Facility Staff
Disagree | Agree
No Response

Behavioral Health Patients
Agree | Agree

Disagree | Agree
No Response

The use of de-escalation is successful in preventing violence

Psychiatric Nurse Response

Psychiatric Facility Staff vs Behavioral Health Patients Response

2005 | 2013
--- | ---
Psychiatric Facility Staff
Agree | Agree
Disagree | Agree
Behavioral Health Patients
Agree | Agree

Disagree | Agree
No Response

Behavioral Health Patients
Agree | Agree

Disagree | Agree
No Response

References:
1 Bock TM (2011) Masters Thesis, Stellenbosch University, South Africa
Physical restraint is sometimes used more than necessary

Psychiatric Nurse Response\(^1\)

<table>
<thead>
<tr>
<th>Response</th>
<th>2005</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree/Totally Agree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree/Totally Disagree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Response</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychiatric Facility Staff vs Behavioral Health Patients Response\(^2,3\)

<table>
<thead>
<tr>
<th>2005</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Facility Staff</td>
<td>Disagree</td>
</tr>
<tr>
<td>Behavioral Health Patients</td>
<td>Disagree</td>
</tr>
</tbody>
</table>

\(^1\) Bock TM (2011) Masters Thesis, Stellenbosch University, South Africa

Management of Violence & Aggressive Behavior: The Process

- Help clinicians detect patients at high risk
- Assist in identifying appropriate steps to manage risk
- Reduce number of injuries to staff & patients
Recognition

- Understand Potential Causes of Violence & Aggression
- Conduct Individual Risk Assessment
- Communicate Risk

Conduct Individual Risk Assessment

Do you use any risk assessment tools in your organization to identify patients with potentially violent or aggressive behaviors?
Psychiatric Settings

• Variety of risk assessment tools available
  – Brøset Violence Checklist (BVC)
  – Violence Risk Screening-10 (V-RISK-10)
  – Violence Screening Checklist (VSC)
  – Brief Rating of Aggression by Children and Adolescents
  – Dynamic Appraisal of Situational Aggression

Emergency and Acute Care Settings

• Emergency Department
  – STAMP – based on 5 behaviors
  – Behavioral Cue Checklist (BCC) – 17 questions

• In-Patient Units
  – Aggressive Behavior Risk Assessment Tool (ABRAT)
STAMP Framework

- **S**taring
  - Prolonged glaring at nurse while engaged in nursing practice
  - Absence of eye contact (culture is a variable here)

- **T**one and volume of voice
  - Sharp or caustic retorts
  - Sarcasm
  - Demeaning inflection
  - Increase in volume

- **A**nger
  - Flushed appearance
  - Hyperventilation
  - Rapid speech
  - Dilated pupils
  - Physical indicators of pain, grimacing, writhing, clutching body
  - Confusion & disorientation
  - Expressed lack of understanding about ED processes
  - Talking ’under their breath’
  - Criticizing staff or the institution just loudly enough to be heard
  - Repetition of same/similar questions or requests
  - Slurring or incoherent speech
  - Talking or yelling inaudibly
  - ‘Resisting’ health care

- **M**umbling
  - Mumbling
  - Talking ‘under their breath’
  - Criticizing staff or the institution just loudly enough to be heard
  - Repetition of same/similar questions or requests
  - Slurring or incoherent speech

- **P**acing
  - Walking around confined areas such as waiting room or bed space
  - Walking back and forth to nurses area
  - Flailing around in bed
  - ‘Resisting’ health care

Behavioral Cue Checklist (BCC)

**More Predictive**

- Only Violent Patients
  - Threat of Harm
  - Walking back/forth to RN station
  - Intimidation

- More Often in Patients that Exhibited Violence
  - Clenched fists
  - Name calling
  - Sharp retorts
  - Aggressive statements
  - Resisting healthcare

- Both Violent & Non-Violent Patients
  - Irritability
  - Demanding attention
  - Increased volume of speech
  - Pacing room
  - Belligerence
Aggressive Behavior Risk Assessment Tool (ABRAT)

<table>
<thead>
<tr>
<th>ABRAT Items</th>
<th>Categories of Violence Risk</th>
<th>Violent Patients by ABRAT Score¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion/cognitive impairment</td>
<td>Low Risk (0)</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Medium Risk (1)</td>
<td></td>
</tr>
<tr>
<td>Agitation</td>
<td>High Risk (≥ 2)</td>
<td></td>
</tr>
<tr>
<td>Shouting/demanding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of physical aggression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threatening to leave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physically aggressive/threatening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History, signs/symptoms of mania</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumbling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Implementing Risk Assessment

- Consider what factors to assess
  - Quantitative risk assessment
  - Clinical observation
- Determine when to perform the assessment
- Identify which assessment scale to use
- Do not label the patient!
Communicate Risk

- Document risk assessment process
- Communicate with care team
- Translate potential risk into care plan (prevention phase)

Prevention

- Prevention Strategies
- Key Prevention Considerations
Prevention Strategies

What prevention strategies do you use to attempt to prevent violent or aggressive behaviors?

• Implement prevention strategies appropriate for care setting
  – Environmental Assessments
  – Security Rounding
  – Limit Setting
  – Behavioral Contracts
  – Time Out
  – Token Economy
Key Prevention Considerations

- **Patient**
  - Incorporate structured risk assessment in care planning
  - Include the patient in the process (transparency)

- **Staff**
  - Establish positive patient-staff alliance
  - Ensure staff is harmonious and acting off same care plan
  - Maintain self awareness

- **Environment**
  - Minimize environmental factors that may impact behavior

De-escalation

- **Immediate Precautions**
- **Interventions to De-escalate**
Immediate Precautions

- Ensure Safety
- Move patient to quieter room or open space *(if possible)*
- Attempt to de-escalate

Interventions to De-escalate

If someone escalates up to the top of the “safety ladder” what do you get?

What types of de-escalation techniques are you using at your organization?
Interventions to De-escalate

- Identify lead to attempt to de-escalate
- Do not leave the area
- Attempt de-escalation techniques
  - Ascertain what patient actually wants & urgency
  - Use empathetic non-confrontational approach
  - Avoid excessive stimulation, aggressive postures and prolonged eye contact
  - Recruit family, friends, care managers to help

Response & Action

- Interventions to Halt Actions
- Incident Management
- Ongoing Quality Improvement
Interventions to Halt Actions

- Activate behavior response team
  - Identify leader of responding team
  - Develop and execute plan
- Close the loop - document and report the incident

Where are violent/aggressive behavior events reported in your organization?

A. Security  56%
B. Case Management  0%
C. Risk Management  27%
D. Safety/Quality  0%
E. Unit Manager/Director  18%
Incident Management – Individual Case

• Conduct review within 72 hours of incident
• Talk to patient, victim of harm and witnesses
• Determine if behavior was related to symptoms of mental or physical illness
• Review behavior response process
• Provide staff support

Incident Management – In the Aggregate

• Are staff adequately trained in recognition & early intervention to de-escalate potential violence?
• Does the analysis reveal other info useful for clinical treatment of patients?
• Are lessons learned from reviews incorporated into treatment plans to improve outcomes & safety for those continuing to treat?
Ongoing Quality Improvement

- Examine how policies address:
  - risk assessment for violence or aggressive behavior
  - care for persons at risk,
  - procedures for management of violence or
- Evaluate policy vs. practice
- Develop measurement strategies

A Success Story in Our Own Backyard*

- Interventions
  - Staff education on de-escalation techniques
  - Implement Response Team for crisis situations
- Outcome: Reduction in mechanical restraint use
- Conclusion
  - Reduction in mechanical restraint use is possible
  - Strong leadership, staff buy-in, provision of feedback, and quality monitoring are key

Is There a Better Way?

Patient refused all medication and became increasingly agitated. Immediately after administering a psychotropic medication to pt against his will, Behavioral Health Hospital staff held pt in a physical hold. Pt struggled against the restraint then appeared to relax. Behavioral Health Hospital staff discovered that pt had shallow respirations and a low pulse. Despite efforts to revive him, pt died . . . approximately one hour after he was restrained. The medical examiner determined pt’s exertion against the restraint was a contributing factor in his death.

Violence Prevention Programs

• Management commitment and employee involvement
• Worksite & event analysis
• Hazard reduction and response
• Safety and health training
• Record keeping and program evaluation

*The Joint Commission’s 45th sentinel event alert recommends that all healthcare facilities identify high risk areas and perpetrators of violence to patients, and then institute prevention strategies to reduce the level of violence.*
Penalties for Violence Against Hospital Workers

CARY, NC — June 22, 2015 — A new North Carolina law, signed on Friday by Gov. Pat McCrory, strengthens penalties for assault on hospital workers. Several states have passed similar legislation amid growing concerns about the safety of hospital staff facing significant risks of job-related violence.

Current law punishes assault on physicians and nurses in emergency departments with a Class I felony, elevated to a Class H should the assault be aggravated. House Bill 560, sponsored by Reps. Josh Dobson (R-Avery, McDowell, Mitchell), Sarah Stevens (R-Surry, Wilkes), and Gail Adcock (D-Wake) and Sen. Buck Newton (R-Johnston, Nash, Wilson), expands the law to include the entire hospital property and does not limit the scope to just physicians and nurses but includes all hospital personnel. The legislation was promoted by the North Carolina Hospital Association and the North Carolina Nurses Association.

Thank You for Sharing!

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Kara Lyven, klyven@ncha.org