Cooling the Hot Climate of Aggression and Assault
Creating a Safe Environment in Mental Health
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Objectives
- Identify components of an effective aggression reduction program
- Discuss steps needed to create a program at your facility

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**Setting**
- 360-bed state treatment facility serving the chronically mentally ill
- Focus = Recovery
- Majority involuntarily committed by court
- 6-month certificates
- 62% male, 38% female
- Average age 46
- Intermediate mental health treatment
- Coverage area = South FL
- 6 million lives
- 30 admissions and discharges each month
- LOS = 10 months, target = 6 months

**Problem?**
- Assaults and aggression were on the rise
- Increase was 10% per year rising to 20% per year in 2009

**Solution?**
- Another task force was just not going to solve the problem. We needed to make a commitment that this was going to be the main focus for everything we were going to do for this year.

**What had we already done?**
- Environmental updates: cameras, monitors, special observation rooms
- Daily contraband checks
- Improved visitor check in process
- Trained staff in de-escalation
Definitions
- Assault - physical attack, may or may not result in injury; pushing, shoving, kicking, hitting, striking another
- Aggression - actions or words that are threatening; verbal threats, property damage, gesturing, throwing things, banging on door/wall

Actions taken
- Clinical Directors of Psychiatry and Psychology to create team to lead the effort
- Unit physician, nurse, CNO, administrator, social worker, quality manager, program director, psychology staff, education staff, community liaison, security staff, and risk manager
- Purpose - review data and literature to make informed decision about next step

Initial Findings
- Literature review = Younger involuntary patient, hx of violence, multiple hospitalizations, dx = neurological impairments, schizophrenia and personality disorder
- 80/20 rule: <20% of the patients engaged in 80% of the events
- Hospital population:
  - 60% hx of aggression/assaultive behaviors
  - 75% multiple hospitalizations
  - Average age of 46
  - 95% schizophrenia or personality disorder
  - 99% involuntary
Phase 1

(Previously, this had already been an FMEA)
- Firm commitment from top clinical and administrative leaders in the organization
- The #1 Strategic Goal
- Immediate record review started for all events
- Grand Rounds referral - 2nd opinion sought
- Unit rewards for those with fewest incidents

Phase 2

(Events did NOT show decrease...)
- Subgroups formed:
  - Medication management - 100% review
  - Policy review - creation of levels for precautionary review and reminders for continued assessment
  - Environmental assessment - "tone" of the unit assessed (noise, music, comfort, rooms, therapeutic interactions)
- TRIF teams started (Traveling Review and Intervention Process Sub-team)

Training and development for staff and patients
- Anger management curriculum standardized (Boston Univ Ctr of Psych Rehab)
- Behavior Plan training on all shifts
- Trauma Informed Care review
- MANDT Transition completed
- Evening programming enhanced
- Nursing as Caring chosen as the nursing theoretical framework, (Zemke & Schonert-Reichl, 2001)
Phase 3
- We (finally) identified that the frontline staff were not as involved as needed.
- Safety became topic of unit community meetings.
- 'Safety tips' created for patients.
- Daily Climate Control emailed to all.
- Units set targets.
- Everyone expected to know daily climate.
- Original team became the steering committee.
- Each unit creating a focused aggression and assault committee.
- Steering committee members were consultants to share best practices.

Climate Control

At the end of Phase 3
- 25% decrease of physical altercations
- 25% decrease in injuries due to assaults
- 64% in serious altercations (ER visit/hosp)
- 60% reduction in restrictive measures (manual holds/seclusions; no mechanical restraint used since 2009)
- 47% in the number of very good and excellent scores on the AHRQ culture
- Quality Week story board winner
The Assault Behavior Reduction Team with their Award Winning Storyboard

Strategies that work...
- Changing from QID/TID to BID as able
- Creating patient flow system
- Changing to Nursing as Caring language
- Caring list and white boards
- Multiple contacts per shift for anyone identified as at risk for assault/aggression
- Communication enhanced at every opportunity
- Safety coaches as front-line champions

Key Points:
- Successful reduction of assaults and aggressive behaviors requires that the effort be driven from the top and must include those at the frontline
- Every patient in this environment needs an individual approach
- It truly does take a village
Implications for Nursing

- Nurses have the opportunity and obligation to promote a safe environment.
- As coordinators of patient care, we must be proactive in risk recognition, skilled in collaboration.
- We are the frontline advocates for our staff and our patients.
- Nursing as a calling requires continued attention so we are authentic, courageous, and reflective about our practice.

Currently in the works...

- Unit targets reviewed annually.
- Ensure continued education.
- Ongoing focus to teach patients about safety.
- Strive for another 20% reduction.
- We have had spikes since this time, focusing more on self-injurious behaviors.

References


