



Objectives

- Identify components of a effective aggression reduction program
- Discuss steps needed to create a program at your facility

Setting

- 340-bed state treatment facility serving the chronically mentally ill Focus = Recovery Majority involuntarily committed by court x 6 month certificates 60% male, 40% female Average age 46 Intermediate mental health treatment



treatment
Coverage area – South FL,
8 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 the year.

What had we already done?

- o Environmental updates: cameras, monitors, special observation rooms
- o 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
- O 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 disorders

 80/20 rule: <20% of the patients engaged in 80% of the events

 Hospital population:

 60% hx of aggression/assaultive behaviors

 95% multiple hospitalizations

 Average age of 46

 95% schizophrenia or personality disorder

 98% involuntary
- - 98% 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
- o Grand Rounds referral 2nd opinion sought
- Unit rewards for those with fewest incidents

Phase 2

(Events did NOT show decrease...)

- Subgroups formed:
 - o medication management 100% review
 - policy review creation of levels for precaution reviews and reminders for continued assessment
- environmental assessment 'tone' of the unit assessed (noise, music, comfort rooms, therapeutic interactions)
- TRIPS 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
- o Trauma Informed Care review
- MANDT transition completed
- Evening programming enhanced
- Nursing as Caring chosen as the nursing theoretical framework (Boykin & Schoenhofer, 2001)

Phase 3

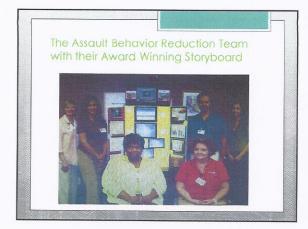
- We (finally) identified that the frontline staff were not as involved as needed
 Safety become topic of unit community meetings
 'Safety Tips' created for patients
 Daily Climate Control emailed to all

- Units set targets
- Everyone expected to know daily climate
- Original Team became the steering committee with each unit creating a focused aggression and assault committee
 Steering committee members were consultants to share best practices

Month	January	February	March	April	May	June	July	August	September	October	November	December	Arnus
2010 Physical Altercations	5		4	6	5	6	8	5	7	6	1	1	60
Unit Goal for 2011	5	5	. 5	0	5	8	- 5		5		5	3	60
2011 Physical Altercations	2	3	1	1	2	2	8	1		2	1	2	32
Unit B Morth	January	Fetruary	March	April	Mary	June	July	August	September	October	November	December	Annual
2010 Physical Altercations Link Goal for 2011	6	5	5	1 5	1 5	1 5	3	4	5	2	4	4	36
2011 Physical Attercations	2	3	4	2	3	3	2	3	4	1	2	1.	31
2011 Physical Altercations	2	3	4	2	3	3	2	3		1	2	1	31

At the end of Phase 3

- o 25% decrease of physical altercations
- o 25% decrease in injuries due to assaults
- o 64% in serious altercations (ER visit/hosp)
- o 60% reduction in restrictive measures (manual holds/seclusions, no mechanical restraint used
- 47% in the number of very good and excellent scores on the AHRQ culture of safety survey'
- Quality Week story board winner



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
- o 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 front line advocates for our staff and our patients.
- Nursing as Caring 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

Anthony, W. A. (2007) Toward a vision of recovery (2^{co} ed.) Boston, MA: Boston University Center for Psychiatric Rehabilitation.

Bowen, B. (2010). Moving away from coercion, enhancing patient dignity and respect. In M. R. Privitera (Ed.) Workplace violence in mental and general healthcare settings. Sudbury, MA: Jones and Bartlett.

Boykin, A., & Schoenhofer, S. O. (2001). Nursing as caring: A model for transforming practice. Sudbury, MA: Jones & Bartlett.

Krayuse, J.E., & Sheitman, B. B. (2004). Characteristics of violent behavior in a large state psychiatric hospital. Psychiatric Services, 55, 183-185.

Lanza, M. L., Relidan, J., Forester, L., & Zeiss, R. A. (2009). Reducing violence against nurses: The violence prevention community meeting. Issues in Mental Health Nursing, 39, 745-750.

Novaco, R. W., (1975). Anger control: The development and evaluation of an experimental treatment. Lexington, MA: Lexington Books.

Questions • dlinette@geocareinc.com • strancis@geocareinc.com	