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Implementation of the Brøset Violence Checklist for Adult Psychiatric Patients

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Background

Violence is a prevalent issue within inpatient psychiatric units worldwide.

It is suggested that about one in five patients who are admitted to acute psychiatric units may become violent.

Violence can negatively affect the patient, other patients, staff members, and the environment.

(Iozzino et al., 2015, p. 1)

Clinical Significance and Clinical Problem

Violence is a large cost burden for facilities. It can also lead to staff turnover, furthering the cost burden.

Implementing the Brøset Violence Checklist (BVC) has shown to reduce violent incidents by up to 68%.

The checked studies revealed that between 24% and 80% of health care workers in acute psychiatric units have been assaulted by a patient at some stage in their career.

When a nurse is experiencing stress and burnout, patients often have poorer outcomes.

Although support from clinical experts regarding the use of the BVC is apparent, using a violence risk assessment tool in psychiatric hospitals is not currently a routine practice and high rates of violent is a prevalent issue.

(d'Ettorre & Pellicani, 2017)
(Hanrahan et al., 2010)
(Van de Sande, 2011)

Project Purpose and PICOT Question

Purpose/Aim

- The purpose of this project is to implement a violence checklist to decrease incidents of violence in the adult inpatient psychiatric setting. The aim of this project is a decrease in incidences of violence from baseline in the adult inpatient psychiatric units by the follow up period.

Review of the Literature

- PubMed, CINAHL, PsycINFO, Google Scholar
- Keywords: “Psych”, “Patients”, “Checklist”, and “Violence”
- Date range: 2011-2021
- Limits/filters: English, inpatient, human, adult, and a ten-year range (2011-2021)
- Inclusion: use of a violence checklist, risk assessment, or predictive tool
- Exclusion: children, geriatrics, intimate partner violence, abuse, reactive treatment, animal therapy, conducted outside of a hospital setting

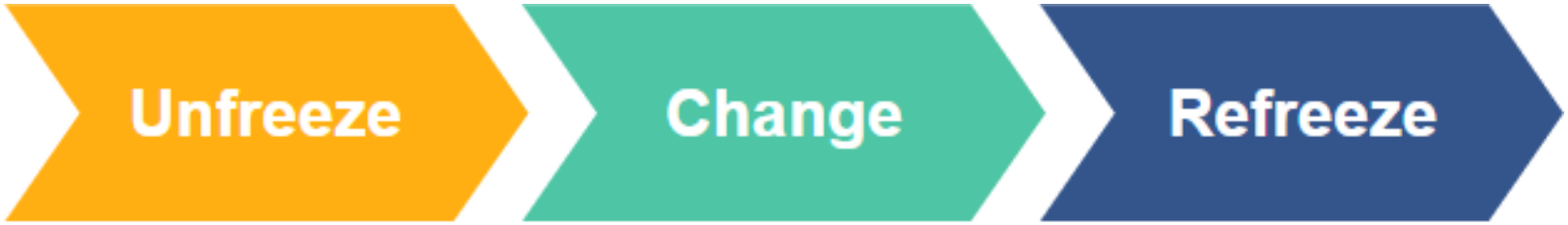
Evidence Synthesis

The Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool was used to appraise single research studies and systematic reviews. The JHNEBP Non-Research Evidence Appraisal Tool was used to appraise non-research evidence. The JHNEBP Evidence Level and Quality Guide was used to assign an evidence level and quality grade to all research.

The BVC, DASA, and HCR-20 demonstrated the greatest levels of accuracy and sensitivity. Ultimately, the BVC was the chosen violence risk assessment tool for this project.

(Blaire et. al., 2016)
(Maguire et. al., 2017)
(Ramesh et. al., 2020)

Theoretical Framework/Model

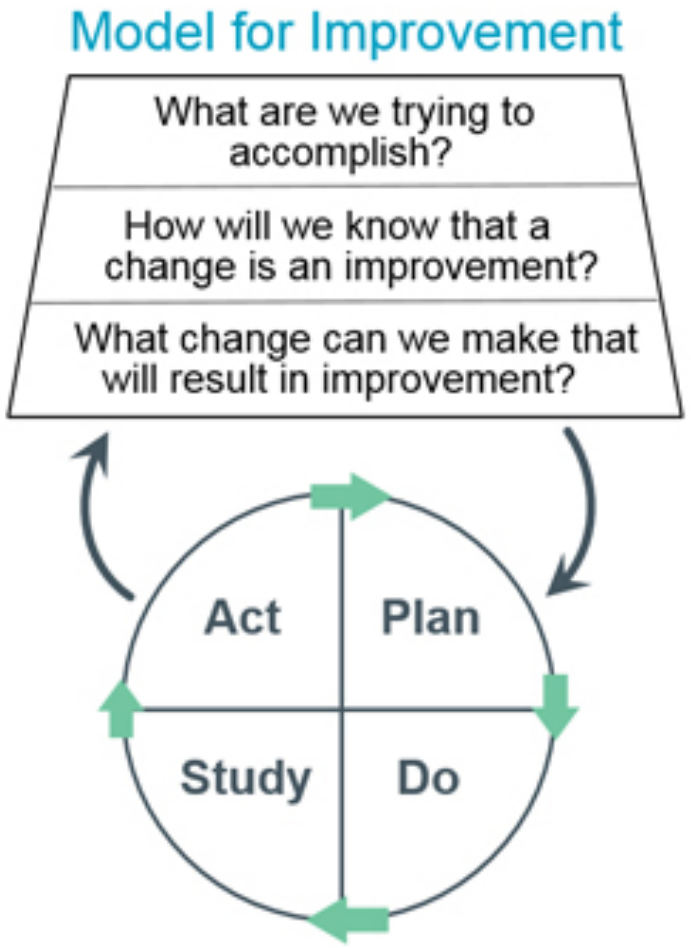


1. Recognize the need for change
2. Determine what needs to change
3. Encourage the replacement of old behaviors and attitudes
4. Ensure there is strong support from management
5. Manage and understand the doubts and concerns

1. Plan the changes
2. Implement the changes
3. Help employees to learn new concept or points of view

1. Changes are reinforced and stabilized
2. Integrate changes into the normal way of doing things
3. Develop ways to sustain the change
4. Celebrate success

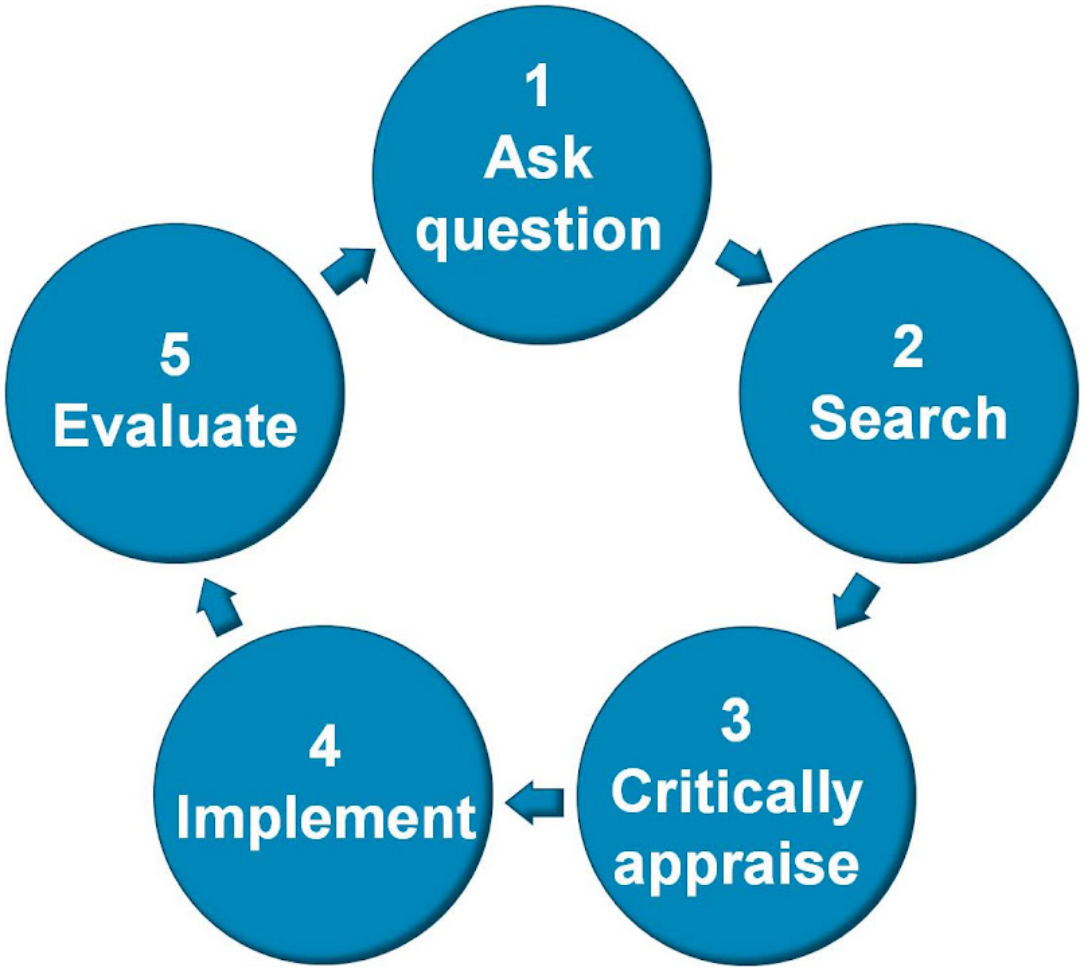
Project Design



Measures of Success

- **Outcome:**
  - Rate of violence compared to baseline at both project sites
  - Number of patients who experience a violent episode in the pre-implementation period versus the implementation period
- **Process:**
  - Staff compliance with use violence risk assessment tool

Guiding Framework: Process



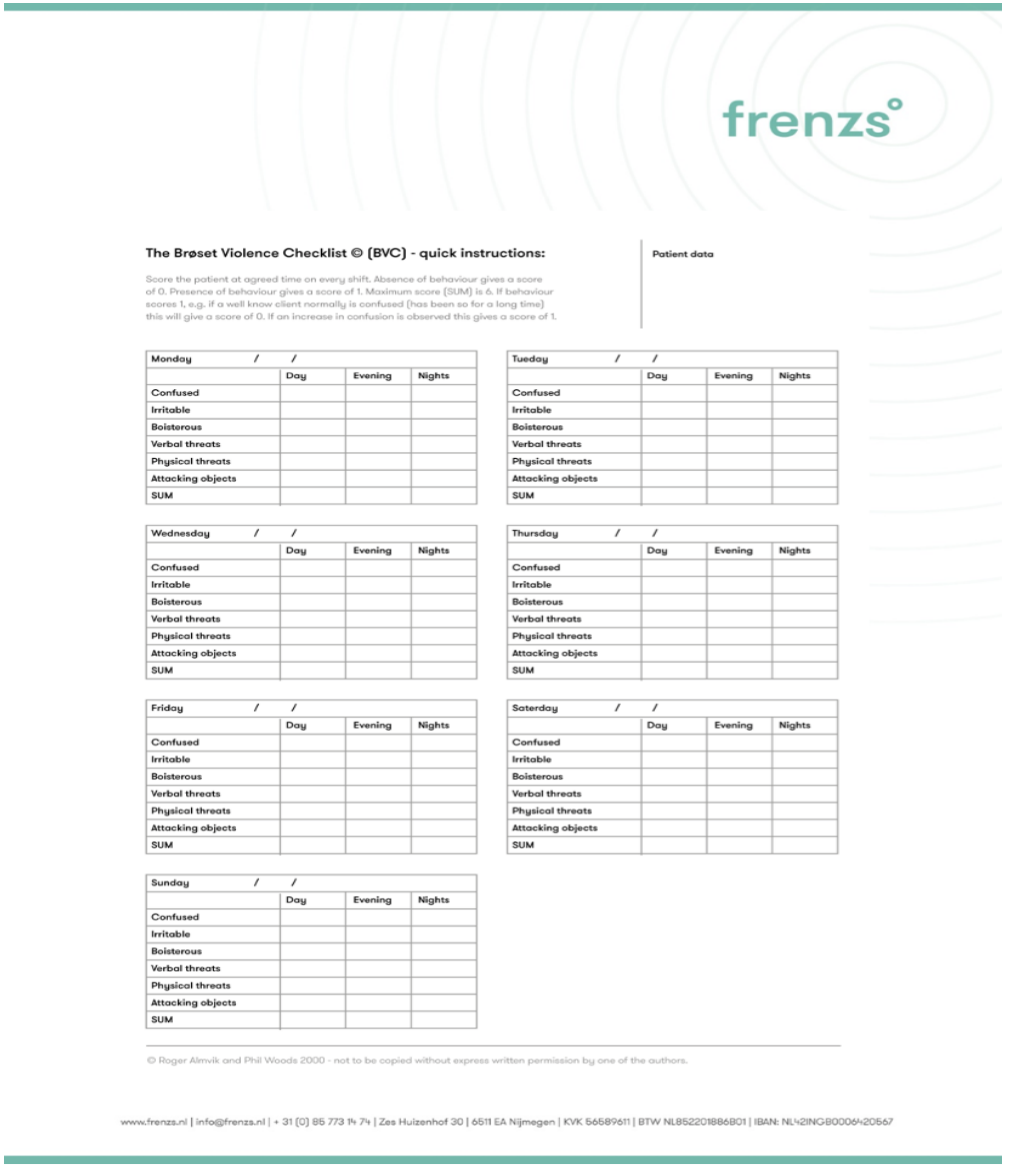
Implementation

- Settings and Population
  - Site one: 11-bed psychiatric unit within a comprehensive facility located in the southern part of the United States
  - Site two: 155-bed acute psychiatric facility consisting of two 13-bed inpatient psychiatric units located in the southern part of the United States
  - Site one serves approximately 40 patients each month. Site two serves approximately 100 patients each month.
  - Approval was granted by the unit director at both project sites.

Implementation Process

- PDSA cycles
  - Choose tool
- Implement
  - Data collection
- Evaluate and disseminate
  - Data analysis
  - Report to team and stakeholders

Brøset Violence Checklist (BVC)



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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 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 data

Monday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Tueday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Wednesday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Thursday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Friday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Saterday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Sunday / /	Day	Evening	Nights
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

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BVC Continued

In addition, plans about how to manage an attack should be made.

Confused	Appears obviously confused and disoriented. 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.
Verbal threats	Where there is a definite intent to physically threaten another person. For example talking 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.
Physical threats	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 slamming 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).

BVC with Recommended Interventions

	Monday / /			Tuesday / /		
	Night	Day	Eve	Night	Day	Eve
Confused						
Irritable						
Boisterous						
Verbal threats						
Physical threats						
Attacking objects						
SUM						
INTERVENTIONS						

0 = no interventions	INIT	DATE/TIME	SIGNAT
1 = verbal de-escalation			
2 = diversional activity			
3 = ↓ stimulation			
4 = sensory modulation			
5 = medication			
6 = continuous supervision			
7 = seclusion			
8 = restraint			

Methods of Evaluation

•Data collection

- Prospective post-implementation x 2 months
- Retrospective pre-implementation chart review x 2 months

•Data variables

- Demographics: age, gender, race
- Admission diagnosis
- Number of violent incidents
- Shift that the BVC was completed on (AM or PM)
- Sum of BVC score
- Interventions that occurred
- Number of patients who experienced at least one violent episode

Findings

- Of the 824 patients, 75% (n=618) did not have a VI, while 25% (n=206) had at least one VI

- Total amount of VI: 889
  - Pre data: 658
  - Implementation: 231

Important Findings

Of the patients who had at least one violent episode, facility one had a statistically significant decrease in the number of violent incidents from pre-data to post-data

- Mean 7.32 to 2.38
- P-value .002

Facility two had a practically significant decease in the use of restraints and seclusion

- Percentage 29.8% to 17.8%

Implications for Practice

- Mental health facilities have become violent and dangerous
- The BVC allows staff to identify when a patient may be at risk for violence, which allows staff to intervene earlier.
- An imminent violence screening tool such as the BVC has shown potential for reducing violence much more effectively than chance.

(Sinclair, 2018)

- Institutional Review Board approval was obtained before initiating any project-related activity
- Determination from both the University of Tennessee and facility found the project was not research involving human subjects
- Letter of support obtained from each site
- All data collected contained no personal information

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