Reducing Violence in the Emergency Department, Improving Perception of Safety: An Aggression Prevention Team Approach

by

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A DNP PROJECT

Submitted in partial fulfillment of the requirements for the
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DNP PROJECT APPROVAL FORM

Submitted by Marilyn Riley in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice and accepted on behalf of the Faculty of the School of Graduate Studies by the DNP project committee.

We, the undersigned members of the Graduate Faculty of The University of Alabama in Huntsville, certify that we have advised and/or supervised the candidate on the work described in this DNP project. We further certify that we have reviewed the DNP project manuscript and approve it in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice.

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ABSTRACT
The School of Graduate Studies
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Degree: Doctor of Nursing Practice College: Nursing

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Title: Reducing Violence in the Emergency Department, Improving Perception of Safety: An Aggression Prevention Team Approach

Problem Statement and Purpose:
Acts of aggression towards nurses has reached never-before-seen levels in Emergency Departments (ED) across the United States (US), and it increases by 15% or more every year. Nurses and ED staff are subjected to violent patients, daily. Nurses often do not feel they have the skills to intervene safely when patients become aggressive, and these behaviors can escalate to harmful levels. Nurses must have a safe environment to practice; therefore, it is imperative violence stops. This DNP project implements an Aggression Prevention Team (APT) to respond in the ED when patients or visitors become aggressive and to improve the nurses' perception of safety.
Population and Setting: The participants were ED nurses in a rural, 25-bed Critical Access hospital.
Project Design: The purpose of the quality improvement project was to address the clinical problem of aggressive patients and the perception of safety among nurses in the ED.
Evidenced-Based Procedure: This DNP project was the implementation of an APT to intervene when patients' behaviors escalate.
Evaluation: The nurses' perception of safety increased based on the mean of the pretest score compared to posttest score. The sample size was nine, and therefore, statistical significance could not be determined. There was, however, an increase in reporting WPV incidents and every aggressive patient that the APT intervened on, the EMR was flagged.
Results: Survey was sent to all fifteen RNs. Survey response rate was 60% (n=9). Four questions focused on the nurse's perception of safety. All four questions showed an increase in the mean score when pretest and posttest were compared. It can be inferred that by scoring higher after the intervention, the nurses' perception of safety increased. During the 3-month pilot program, the APT responded thirteen times. At the conclusion of the pilot, nurses responded with feelings of improved perception of safety knowing the team was available in aggressive patient situations.
Conclusion and Implications: The ED is an environment where WPV occurs on a regular basis. The perception of safety is influenced by supports in place, such as nursing supervisor, security personnel and the APT. Implementing an APT in the ED has improved the perception of safety among the nurses. Nurses who care for patients that are aggressive, feel supported by the APT and feel more confident in caring for these patients, because they have the additional support the APT offers. Nurse leaders should facilitate effective WPV interventions, such as developing an APT, and reporting programs to provide nurses with a safe environment to practice.

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Identification of the Problem

Acts of aggression towards nurses and staff has reached epidemic levels in Emergency Departments (ED) across the United States (US) and internationally, with a reported increase of 15% or more every year (Hutton, Vance, Burgard, Grace, & Van Male, 2018a). The Occupational Safety and Health Administration (OSHA) (2019), describes workplace violence as a behavior or threat of violence, harassment, or threatening gesture that occurs in the work place. Nurses and staff who work in ED are subjected to violent patients, daily, and these acts of aggression in the ED are a form of workplace violence (WPV).

Nurses, often, do not feel they have the skills to intervene safely when patients become aggressive, and patient behaviors can escalate rapidly to harmful levels. This aggression can begin as verbal threats, cursing, or derogatory words and quickly escalate into a physical altercation. Nurses must have a safe environment to practice; therefore, it is imperative that nurse leaders intervene to mitigate the violence (Wong, Ray, & Iennaco, 2019; Zager, Dulaney, & Jacobs, 2010). The purpose of the Doctor of Nursing Practice (DNP) Quality Improvement (QI) project was to assess the nurses' perceptions of safety after the implementation of an Aggression prevention Team (APT) to de-escalate patients'' behaviors.

Evidence of the Problem

National Level

Nationally, WPV has an estimated annual cost of $4.2 billion (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). WPV accounts for 1.7 million non-fatal assaults each year and results in physical, personal, emotional, professional, and organizational consequences. Organizational

consequences include medical treatment costs, and turnover (Hassankhani, Parizad, Gacki-Smith, Rahmani, & Mohammadi, 2018; Lanctôt & Guay, 2014; Lipscomb & El Ghaziri, 2013; Martinez, 2016; McPhaul, London, & Lipscomb, 2013; Mueller & Tschan, 2011; Myers et al., 2016; Samuels, Hunt, & Tezra, 2018). The costs of WPV are also driven by the treatment costs for staff involved in an incident, missed shifts and long term sequelae such as decreased job performance, and morale, staff retention, depression and post-traumatic stress disorder (PTSD) (Gillespie, Pekar, Byczkowski, & Fisher, 2017; G. L. Gillespie, Gates, & Fisher, 2015; Hutton, Vance, Burgard, Grace, & Van Male, 2018b; Kowalenko, Gates, Gillespie, Succop, & Mentzel, 2013; Speroni et al., 2014; Yang, Stone, Petrini, & Morris, 2018). According to the Bureau of Labor Statistics, (2019), 18,400 workers in the private sector workforce were affected by trauma from nonfatal workplace violence significantly enough to require time off from work. The Bureau of Labor Statistics (2019), posits that victims of WPV were most often female, 71% worked in healthcare and social services, 18% required 31 or more days away from work to recover, and 25% required 3 to 5 days away from work.

Local/Clinical Site

In the Indiana University Health Frankfort ED, there has been a 100% increase in violent patients in the past 12 months. This increase can be attributed to the high rate of opioid misuse in Indiana, and particularly, Clinton County. The patients who present with violent behaviors are under the influence of a substance approximately 25% of the time. These data are collected through daily security reports and reported monthly. (*Appendix A-IU Health, Frankfort-2019-Security Data, Appendix B-Security Events-Behavioral Reporting 2019*). Patients under the influence of a substance, frequently exhibit verbal aggression through the use of foul language, and if not de-escalated quickly, can rapidly escalate to aggressive behaviors.

In June 2019, the Chief Nursing Officer (CNO), who is the DNP Project Leader, identified patient and visitor violence as a strategic priority for 2019 and 2020. To understand the problem, the CNO launched an awareness campaign with all hospital staff. This campaign supported staff to enter incident reports in Clearsight, an incident reporting system, anytime a patient exhibited aggressive behaviors. To further increase awareness and staff support, the security team was asked to intervene and search any patient that was considered "high risk." Those patients considered high risk include patients under the influence of a substance, patients with suicidal ideation, inmates, or any patient acting out. Once these patients are identified, the staff call security to search the patient's belongings for weapons or drug paraphernalia. Because these patients are on hospital private property and the security staff are not police officers, they have the endorsement to search these high-risk patients' belongings. This process has identified several safety risks with weapons and substances being found. *(Appendix C- Security Searches Summary-2019)*.

Significance of the Problem

The sections below provide details on the significance of the problem to patient care and nursing practice.

The Problem Related to Patient Care

Patient safety is negatively impacted, directly and indirectly, when nurses who have experienced WPV, have higher rates of absenteeism, turnover and lower productivity (Vrablik et al., 2019; Weinand, 2010; Weiss, 2016; Wressell, Rasmussen, & Driscoll, 2018; Yang et al., 2018). Patient care quality is negatively affected when staff are injured and unable to work, creating short staffing situations. In these situations, the typical remedy is to utilize per diem or float staff to cover the staff absence. These float staff are less familiar with the unit and patients,

and experience assaults at three times the rate compared to staff permanently assigned to that unit (McPhaul et al., 2013). This cycle of violence and injuries only compounds the problem. Exposure to WPV, in any form, may increase the risk of adverse responses by staff, ultimately leading to lessened quality care and patient perception that the quality of care is reduced. (Lipscomb & El Ghaziri, 2013).

The Problem Related to Nursing Practice

Nurses are vulnerable to verbal violence by patients or visitors. Repeated verbal abuse can lead to nurses feeling unsafe in the work environment. Many nurses do not identify or perceive verbal abuse as WPV, because no one was physically injured. This perception of WPV perpetuates the problem. This violence has many consequences, including psychological and physical stress, compassion fatigue, and burnout and could ultimately result in the nurse leaving the organization or the profession entirely (Bourgault, 2019; McPhaul, Vanhoy, Perdue, Moore, & Handelman, 2011).

Significance of the Project to the Problem

Workplace violence is a complex issue in healthcare, based on multiple factors, such as lack of resources for mental health, the opioid epidemic, hospital understaffing, perceptions that management does not support nurses, and lack of education and training for staff that leads to a culture and belief that violence is a part of the job (Sever, 2019). The time is now for nurse leaders to address the issue of WPV with interventions shown to mitigate violence. One widely accepted intervention in healthcare settings that is particularly successful in the ED is using a response team to intervene and support the staff in violent situations (Kelley, 2014; Elizabeth L. Pestka et al., 2012; Wong, Wing, Weiss, & Gang, 2015; Zicko, Schroeder, Byers, Taylor, & Spence, 2017).

Using rapid response teams in medical emergencies is widely accepted in healthcare settings. The same concept can be applied when using a behavioral emergency response team (BERT), a relatively new concept in healthcare. Having a multidisciplinary and comprehensive approach to aggressive patients rather than a show of force with security personnel can be more appropriate (Parker, 2019). A BERT code deploys a team to de-escalate an aggressive situation and provide a safe environment for staff and patients (Ambrose, Wing, Weiss, & Gang, 2015; Loucks, Rutledge, Hatch, & Morrison, 2010; Parker, 2019; Elizabeth L. Pestka et al., 2012; Wong et al., 2015; Zicko et al., 2017). To date, the research reports of behavioral emergency response teams show promising outcomes such as a decrease in restraint use, reduction in WPV, decrease in active violence codes and total number of calls, and a decrease length of stay. Additionally, these teams improve overall staff morale and positively affect staff perception of safety (Ambrose et al., 2015; Loucks et al., 2010; Parker, 2019; Elizabeth L. Pestka et al., 2012; Wong et al., 2015; Zicko et al., 2017). Furthermore, the teams can be successfully implemented with little to no additional costs to the organization and use existing hospital personnel (Parker, 2019).

Because of the increase in aggressive patients in the ED, at the IU Health Frankfort Hospital, the CNO developed a Health and Safety Taskforce. This taskforce started its work in April 2019 as a multidisciplinary group including RNs, Nursing Supervisor, CNO, Security Supervisor, Chaplain, Facilities Manager, Educator, Registrar, Quality Manager and Risk Manager. This taskforce was charged with understanding the level and frequency of violent occurrences in the ED. When the taskforce was developed, a gap analysis was conducted and revealed there was not a policy in place regarding patient or visitor behaviors, nor did staff understand the need to report WPV incidents. Because of the gap analysis, the *Patient and*

Visitor Behavior Policy was developed in late 2019. *(Appendix D-Patient and Visitor Behavior Policy)*. Since its inception, the taskforce has focused on understanding the reporting and frequency of events, supporting staff, and developing policies. *(Appendix E- Health and Safety Taskforce Charter and Goals for 2019 and 2020).*

The staff at IU Health Frankfort Hospital are trained annually on verbal de-escalation techniques. The staff are not trained on how to de-escalate a situation once it has elevated into a physical altercation. When staff are involved with aggressive patients, they feel unsafe. This perception of feeling unsafe, has been expressed to the CNO during leader rounds and in staff meetings. The ED nurses have also expressed that they do not feel safe when there is no security officer or nursing supervisor in the building to intervene when aggressive patients are in the ED. The RNs perception of safety is a valid concern, particularly with the increase in violent patients.

The CNO, identified the issue of patient and visitor violence as a top priority and has committed to providing the necessary resources to develop a program to mitigate the violence (Riley, 2019). Funding was necessary to support the increased staffing of Nursing Supervisor and Security Officer. The financial impact is due to adding a 0.3 FTE to the Security budget and a 0.3 FTE to the Nursing Administration budget. The approximate cost of adding both these FTEs is $68,000, annually. These two additional FTEs have been added and allocated in the 2020 budget. On February 1, 2020, both FTEs were secured and there is now 24-hour per day coverage for both the Nursing Supervisor and the Security Officer roles.

PICOT Question

To address this clinical problem, of WPV, this DNP project was developed based on the following PICOT question:

Does the implementation of an Aggression Prevention Team (APT), affect nurses' perception of safety in the work environment, the reporting of WPV incidents, and the identification of high-risk patients in the EMR, over a period of three months?

Synthesis of the Evidence

Search Strategy

A literature search was conducted with keywords: Workplace Violence, Healthcare, Interventions, Nurses, Emergency Department, Perception, Safety, Prevention and Mitigation. Databases used included: The Cumulative Index to Nursing and Allied Health Literature (CINAHL) PubMed (Medline), and OVID Nursing Journals were searched for articles. This literature review was conducted to explore and understand the literature related to successful mitigation of WPV, and to develop interventions supporting staff and patients. This literature review included relevant studies related to WPV affecting nurses in the ED, how WPV affects perceptions of safety and the interventions to address WPV. Of the 365 articles found within this search, 99 were relevant and reviewed for this DNP project.

Inclusion and Exclusion Criteria

The purpose of this literature review was to find applicable, primary, secondary, systematic literature reviews, and guidelines related to WPV affecting nurses in hospital EDs, nurses' perception of safety, and the interventions addressing WPV. The studies chosen for this literature review primarily focus on hospital EDs and ED nurses. To narrow the review, and because of the differences in international healthcare settings, this review only included studies in U.S. hospitals. Findings from the literature search revealed that WPV impacts the staff in the entire hospital and is influenced by the hospital culture (Evans, 2017). Because WPV reduction

strategies must be broad enough to include hospital culture, relevant studies which focused on hospital safety culture were included to view the hospital as a whole.

Workplace Violence Reporting

Reporting WPV is, in part, an element of the overall problem (Speroni et al., 2014). While the incidence of violence in EDs varies according to the definition used, the actual reporting of violence is a substantial factor in obtaining a precise rate of occurrence. Several articles identify under reporting of WPV due to the perception of harm, staff feeling it is part of the job, or excessive paperwork (Schnapp et al., 2016; Speroni et al., 2014; Taylor & Rew, 2011; Wressell et al., 2018; Yang et al., 2018). Nurses may not report WPV due to barriers such as: a workplace culture that does not support a zero-tolerance policy, a perception that violent events are accepted, a lack of standard definition of WPV, fear of being blamed for the incident, or lack of awareness of the reporting system (Gacki-Smith et al., 2009; Hogarth, Beattie, & Morphet, 2016; Hyland, Watts, & Fry, 2016; Kvas & Seljak, 2014; J. Morphet, Griffiths, Beattie, Velasquez Reyes, & Innes, 2018; Julia Morphet, Griffiths, & Innes, 2019; Schwartz & Bjorklund, 2019; Speroni et al., 2014; Swanson, 2014; *Taking a Stand Against Workplace Violence*, 2017; Taylor & Rew, 2011; Vos, 2020).

According to the United States Bureau of Justice Statistics (2019), the reported rate of WPV among nurses was 3.9%. The literature describes variations in the reporting of WPV rates and correlate decreased rates of reporting associated with nurses feeling lack of support from leaders, believing nothing will be done or having a negative experience with the reporting process (Ahc, 2018b; Arnetz, Hamblin, Ager, Aranyos, et al., 2015; Arnetz, Hamblin, Ager, Luborsky, et al., 2015; Findorff, McGovern, Wall, & Gerberich, 2005; Gacki-Smith et al., 2009; Hogarth et al., 2016; Hyland et al., 2016; Kvas & Seljak, 2014; J. Morphet et al., 2018; Julia

Morphet et al., 2019; Speroni et al., 2014; Swanson, 2014; Taylor & Rew, 2011; van Melle, van Stel, Poldervaart, de Wit, & Zwart, 2018; Vos, 2020; Weiland, Ivory, & Hutton, 2017).

To improve the rates of reporting WPV, nurse leaders need to better understand the reasons why nurses do not report the events when they occur, and need to better comprehend the factors nurses consider when deciding to report or press charges when patients are involved. Nurses are hesitant to report these events, particularly when those patients are mentally impaired or have an altered level of consciousness and violence from patients and visitors is often accepted in this fast-paced, stressful work environment (McPhaul et al., 2013).

Reporting mechanisms can be surveys, questionnaires, or incident reports. The Emergency Nurses' Association (ENA) and the American Hospital Association (AHA) have developed questionnaires that can identify nurse's level of perceived safety, prevalence, and rate of occurrence of WPV (J. Morphet et al., 2018; Speroni et al., 2014; Taylor & Rew, 2011).

Nurses' Perception of Safety

In 2009, the ENA conducted a large workplace violence surveillance study, in which they collected data from ED nurses on a quarterly basis. This online survey focused on WPV and the how they responded to the violence. These data were collected in a cross-sectional study including over 3000 ENA members. The study was aimed at understanding emergency nurses' experiences and perceptions of WPV. Based on the results of that study, the ENA developed several evidence-based resources to help address and mitigate violence in the ED (Gacki-Smith et al., 2009; McPhaul et al., 2013; Medicine, 2015). Several studies in the literature review, referenced the ENA study and the perceptions of nurses related to WPV. Nurse leaders can use the results from this large study to develop strategic plans to identify WPV, support nurses in reporting WPV, and implement strategies to mitigate the violence.

The Joint Commission (TJC) describes measures organizations must take to ensure a safe working environment for staff. In the *Safety Culture Project*, were workplace safety, patient safety and safety culture were identified as elements organizations should incorporate into their culture (Stockwell, 2018). Patient safety and staff/workplace safety are necessary in organizations because, patient safety cannot be achieved without workplace safety. Many patient safety lessons learned can easily be applied to workplace safety. A WPV mitigation program can be sustained when the organization's culture is focused on safety (Dewi, 2018; Stockwell, 2018; Wong et al., 2019).

Nurses' perception of safety in the workplace is multifactorial. Nurses' perceive a safe environment when they have security staff present or readily available. Besides security staff presence, nurses perceive an increase in safety when the environment is not crowded, noisy or there are not long wait times, and they have control of visitors coming into the unit (J. Blando, Ridenour, Hartley, & Casteel, 2015; J. D. Blando, O'Hagan, Casteel, Nocera, & Peek-Asa, 2013).

Patient characteristics related to aggression

Patient behavior, patient care, and situational events emerged as common elements in several studies. These studies identified factors that influence WPV as patient behavior and/or history of violence, work demands, unit rules, and lack of violence prevention programs and training (Park, Cho, & Hong, 2015; Vandecasteele et al., 2015; Wolf, Delao, & Perhats, 2014).

Violence in a healthcare environment may stem from a confused, distressed, mentally ill, or intoxicated patient. Patients under the influence of a substance are at higher risk for violent or aggressive behaviors and gestures towards staff (Ahc, 2018a, 2018b; Bresler & Gaskell, 2015;

Gillespie, Gates, & Berry, 2013; Powley, 2013). Patients who exhibit violent behaviors in the ED, often are under the influence of a substance.

These substances can range from methamphetamines, opioids, cocaine, and synthetic cathinones, such as bath salts. Methamphetamine, also known as crystal meth or ice, is recognized for its association with violent behavior (McKetin et al., 2014). Violence associated with methamphetamine use is characterized by its unpredictable and often bizarre behaviors, that can cause drug induced paranoia (Armenian et al., 2019).

Opioids and cocaine usage have been linked to violent behaviors and blunt force trauma injuries (Armenian et al., 2019). Several studies support that patients who use these substances exhibit aggressive behaviors, violent outbursts and paranoia (Hamilton & Goeders, 2010; McKetin et al., 2014; Tyner & Fremouw, 2008).

Patients with a history of violence are more likely to become violent (Alexandercikova et al., 2013; Friedmann et al., 2008; Hegney, Tuckett, Parker, & Eley, 2010). One of the most substantial risk factors for violent behaviors is a history of violence (Alnıak, Erkıran, & Mutlu, 2016). Patients with a history of previous violence should be identified in the EMR so staff can be proactive when caring for them. By identifying the patients in the EMR, staff can know the history of violence and take steps necessary to protect themselves and others. Schmidt et al. (2019) suggested the need for a comprehensive and ongoing risk assessment and recommended a flag within the electronic medical record to indicate a history or risk of violent behaviors. This best practice was echoed by the Emergency Nurses Association (2020).

Workplace Violence Guidelines/Toolkits

Several nursing organizations have developed position statements or toolkits to address this issue. The American Nurses Association (ANA) (2015), published a position statement on

incivility, bullying, and workplace violence outlining specific responsibilities for both registered nurses and employers. The ANA (2019) recently launched the #EndNurseAbuse Campaign as a call to action for all nurses, healthcare providers, and organizations to support nurses and end workplace violence. The American Organization of Nurse Leaders (AONL) and Emergency Nurses Association (ENA) developed guiding principles and a toolkit to mitigate violence in the workplace (Medicine, 2015).

The AONL and the ENA have developed eight Guiding Principles for mitigating violence in the workplace. These include:

- Violence can and does happen everywhere
- Healthy work environments promote positive patient outcomes
- All aspects of violence, including those involving patients, families, and colleagues, must be addressed
- A multidisciplinary team is needed to address WPV
- Everyone in the organization is accountable for upholding behavior standards
- When members of a healthcare team identify an issue that contributes to WPV, they have an obligation to address it
- A culture shift requires intention, commitment, and collaboration of nurses with other healthcare professionals at all levels
- Addressing WPV may increase the effectiveness of nursing practice and patient care
- Interventions to address WPV range from education to development of response teams to de-escalate the situation when aggression occurs. (Medicine, 2015, p. 280).

Under The Joint Commission's (TJC) Sentinel Event policy, "rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a patient, staff member, licensed independent practitioner, visitor, or vendor while on site at an organization is a sentinel event that warrants a comprehensive systematic analysis" (*Sentinel Events*, 2017, p. 1). They support that every organization will "specifically define acceptable and unacceptable behavior and the severity of harm that will trigger an investigation" (*Sentinel Events*, 2017, p. 1).

Workplace Violence Interventions

Several studies in the literature focus on the interventions aimed at addressing WPV. Interventions include education programs for staff on identification, de-escalation techniques, and preparation to manage violent or aggressive patients, and development of response teams. Findings from these studies are similar to other reports in the literature suggesting that with some basic training, nurses can be more prepared to manage aggressive situations (Beech & Leather, 2006; Mikalonis, 2018; Nachreiner et al., 2005; Wolf et al., 2014; Wressell et al., 2018).

De-escalation

Several studies support de-escalation techniques and behavioral intervention teams (Gerdtz et al., 2013; Mavandadi, Bieling, & Madsen, 2016; Robbins, 2019; Schwartz & Bjorklund, 2019; Wong et al., 2015). De-escalation strategies should be employed as the first line of defense when experiencing aggression and/or potential violence in the healthcare workplace. Organizations need to develop a comprehensive program of continuing professional education on de-escalation and aggression management, skill acquisition, peer mentoring and support.

Behavioral Emergency Response Team

Behavioral Emergency Response Team (BERT) is one intervention that has demonstrated success in non-psychiatric settings (Zicko et al., 2017). In non-psychiatric settings, these teams are a relatively new concept. The behavioral intervention team can assist and support the care team when patients become aggressive. In studies identifying BERT as a viable option to mitigate WPV, researchers found that de-escalation of the violent event and support of staff when aggressive behaviors occur are necessary in areas of the hospital where violence takes place (Angland, Dowling, & Casey, 2014; Ashton, Morris, & Smith, 2018; Casey, 2019; Hartley,

Ridenour, Craine, & Morrill, 2015; Martinez, 2016; Powley, 2013; Ramacciati, Ceccagnoli, Addey, Lumini, & Rasero, 2016; Rintoul, Wynaden, & McGowan, 2009; Robbins, 2019; Wong et al., 2015; Zicko et al., 2017).

According to Pestka, Hatteberg, Larson, Zwygart, Cox, and Borgen (2012), they described the implementation of BERT, and concluded this valuable intervention is not only an excellent resource for staff to utilize in behavioral emergencies to improve patient and staff safety, it also increases staff satisfaction. Zicko et al. (2017), published an article about initiating a BERT in a non-behavioral health unit that resulted in a decrease in restraint usage and significant decrease in staff assaults. The researchers determined that a BERT initiative can offer a significant resource team which increases patient and staff safety in facilities with or without a mental health unit. In a similar study by Kelly (2014), the implementation of an emergency department rapid response team reduced patient violent behaviors and provided support for team members. The mission of the team was to provide the best care to behavioral patients by responding when patients' behaviors escalated.

These teams are similar to rapid response teams (RRTs) "that were initially developed to prevent deaths outside critical care units by providing specialized resource teams who could respond to patients in emergent situations" (Loucks et al., 2010, p. 60). These teams support the initiatives of The Joint Commission and the National Patient Safety Goals (2018), that require a method to enable staff members to gain assistance from specialty personnel when they have recognized a potentially worsening change in patient condition.

These multidisciplinary teams assist staff during escalating situations, and by implementing a behavioral emergency response team (BERT), the nurse's perception of safety improves due to the support the team provides (Parker, 2019). According to Pestka et al., (2012),

the most common situation for team intervention is with verbally aggressive patients. The team can respond and use techniques to calm and help the patient refocus (Chappell, 2015; Stempniak, 2017). Once the team arrives, they try de-escalation and if that fails, they move through other interventions including medications and restraints (Chappell, 2015; Stempniak, 2017). Stempniak (2017) stated that behavior response teams were reported as effective and with the team in place, 75% of the nurses reported feeling an increased sense of support and safety.

Practice changes related to behavioral emergency response teams (BERT) or APT, are evolving. More organizations are implementing these teams to support the staff, patients and reduce the violence in the ED. Studies support the development of programs and procedures on how to prevent, intervene, investigate, and report patient violence against healthcare workers. These interventions will not eliminate the problem, but will provide support for staff and a safer work environment (Warren & Warren, 2017; Wong et al., 2019; Wong et al., 2015; Wressell et al., 2018).

Conceptual Framework

The revised Iowa Model of Evidence-Based Practice framework was used for implementing the Aggression Prevention Team. This framework is commonly used for the evidence-based practice implementation and was introduced in the early 1990s by a group of nurses from the University of Iowa Hospitals and Clinics to direct clinicians how to improve quality care. The framework included ten steps involving the three main key decision points: "(a) *Is this topic a priority?* (b) *Is there sufficient evidence?* (c) *Is change appropriate for adoption in practice?*" (Buckwalter et al., 2017, p. 178).

By applying this framework to the DNP project, the three decision points listed can be answered:

Is this topic a priority?

- At Indiana University Health Frankfort Hospital, there has been a 100% increase in violent events in the ED. The Health and Safety Taskforce was developed by the CNO and implemented at the hospital in April 2019. The CNO collected data from daily incident reports to understand the depth of the violence in the ED.

Is there sufficient evidence?

- The evidence was collected from the literature review and data from the hospital's daily incident reports. The evidence identified the problem and the gaps. This evidence supports the need for the project.

Is the change appropriate for adoption in practice?

- The literature supports the implementation of a response team to support staff and mitigate the violence in the ED. This intervention has demonstrated effectiveness in other ED in the US, and therefore implementation in the IU Health ED during this project, promote adoption into practice. These key decisions are crucial for the success of this project. The revised Iowa Model for evidence-based practice to promote excellence in healthcare is shown in *Appendix F-Iowa Model* (Buckwalter et al., 2017).

Project Design

This quality improvement project was developed after an extensive review of the literature pertaining to WPV in the ED, nurses' perception of safety and the interventions to address and mitigate the violence. The purpose of the DNP project was to address the clinical problem of aggressive or violent patients in the ED and understand nurses' perception of safety in the ED. This project was designed to assess the nurses' perceptions of safety, after

implementing the Aggression Prevention Team (APT) to intervene when patients' behaviors escalate.

Setting

This DNP project was conducted at Indiana University (IU) Health Frankfort Hospital, located at 1300 South Jackson Street, Frankfort, Indiana. Frankfort Indiana is a rural city in Clinton County, with approximately 32,000 residents, of which, 30% are of the Hispanic or Latino heritage. The median household income of Clinton County residents is $51,659.

The hospital is a 25-bed, critical access hospital with an eight-bed ED that is full service and available to the community, 24 hours per day, 7 days per week. The daily census averages twenty-five patients, nearly 9,500 ED visits per year. The medical conditions seen in the ED vary. Patients present with complete cardiac arrest, S-T Elevated Myocardial Infarction (STEMI), drug overdoses, suicidal ideation, mental health disorders, minor medical conditions such as, sprained ankle and streptococcus pharyngitis. The ED cares for patients of all ages, ethnicity, and socioeconomic status.

The staffing model for the ED is two Registered Nurses, one Unit Support Tech (unlicensed assistive personnel), and one ED Board Certified Physician. There is also a Nursing Supervisor in house, 24 hours per day, 7 days per week. The Nursing Supervisor is responsible for throughput, assessing critical patients, assisting staff with tasks, assisting with transferring patients to higher levels of care, and intervening in aggressive situations. There is a security officer in the hospital 24 hours per day, 7 days per week.

This project has the complete support of the President and CNO. Having complete support of the Executive Leadership at IU Health Frankfort, the financial resources, and nursing staff support will facilitate the implementation of the project.

Population/Participants

The population studied was the ED RNs. 15 nurses were eligible to participate, including full- and part-time, and per diem nurses. The average tenure of RNs in the ED is eight years. Nine nurses hold a baccalaureate in nursing, six hold an associate degree in nursing. One nurse is certified in emergency nursing. Consent was implied upon completion of the survey, meaning that nurses could opt out by not completing the survey. With the DNP project leader being the CNO, additional caution was taken to ensure that the RNs perceived their participation to be voluntary and anonymous. A brief description of the survey intention and voluntary participation was included in the email sent to participants. (*Appendix G-Email sent to participants*) The APT intervention was applied to patients in the ED with aggressive behaviors when RNs felt they needed additional support beyond verbal de-escalation techniques already in place.

Design

This DNP project design was a single site, quality improvement project. Before and after implementing the intervention, the project participants received the *Workplace Violence Staff Assessment Survey* (2017). The project leader used this survey tool to understand the perceptions of safety among the ED nurses, how often violence occurs, and how nurses define WPV. The intervention implemented was the APT, and the ED nurses were surveyed three months' post intervention and compared to the pre-intervention survey responses. The project design included monitoring quality and safety outcomes through the daily Clearsight incident reporting system and the daily Safety and Security Reports. In addition, using the PDSA cycle allowed the team to slightly change the process to improve. Continual evaluation and re-evaluation of the process is critical, as this information can be shared with the key stakeholders to determine success of the workplace violence initiative.

Institutional Review Board (IRB) approval was received from IU Health on April 29, 2020 and from the University of Alabama in Huntsville on May 23, 2020. The survey was sent by the DNP project leader to all RNs in the ED via their organizational email on June 1, 2020. The post-intervention survey was sent using the same method on September 1, 2020.

Education

Education was provided to all RNs, support staff and the members of the response team described below. It was provided by the CNO/DNP project leader and the Clinical Educator, and began with statistical information on the depth and breadth of the WPV problem both nationally and locally. Additional training was provided to the nursing supervisors on how to enter a designation into the EMR to flag the chart of patients who have exhibited aggressive behaviors. This helps identify those patients with a propensity of violence, so staff can be proactive in their interactions. *(Appendix-H- Education PowerPoint)*

Aggression Prevention Team Development

To reduce violent behaviors exhibited by patients in the ED, a multidisciplinary response team was developed. The APT includes: RNs, security, chaplain, nursing supervisor, facilities personnel, and nurse manager. This multidisciplinary team supports the staff and patients in aggressive or violent situations. The APT is available 24-hours a day, seven days a week to intervene when patients exhibit aggressive or violent behaviors. Target behaviors are potentially disruptive or threatening actions of individuals with a psychiatric history or other patients who compromise the safety and well-being of themselves, other patients, visitors, or staff members.

Once an aggressive or violent situation is identified, staff activate the team by an overhead page. Standard work was established with step by step instructions on how and when to call the APT. *(Appendix-I-APT Standard Work-Nursing Supervisor and Appendix J- APT Call*

Tree-Process for calling APT)) The team arrives and has a pre-huddle with the bedside nurse and MD to understand the situation and develop an individualized plan for the patient. After the event, the Nursing Supervisor or the Security officer lead the team in a debrief to understand what went well, what could be improved, and if anyone was injured. This debrief is essential in identifying any gaps in the process. *(Appendix K-APT Debrief tool)*. The team roles must be clearly delineated and defined, so everyone on the team understands their role and the expectations. The APT members and roles are outlined in Table 1.

All calls are logged by the hospital operator, who announces the event overhead to alert the team of the situation and the location. The call log was reviewed weekly and correlated with the completed debrief tools to understand the number of calls, and trends in time of day, staffing levels, and other environmental factors that could influence the need for the APT.

To ensure fidelity of the team and the intervention, the DNP leader was also notified of each call to the APT. The DNP project leader responded to the incident and observed the process during normal working hours. This was documented in an audit tool that confirms the team was meeting the objectives of the project and performing as expected. *(Appendix-L-APT Audit Tool)*

Evidenced-Based Procedure

The evidence supports a multifaceted approach to addressing WPV in the ED. The evidence-based procedure selected for this DNP project was the implementation of an Aggression Prevention Team. The steps in implementing the Aggression Prevention Team are outlined below.

Recruit participants.

In this QI project, all the ED RNs were invited to participate. Once IRB approvals were obtained from both IU Health and UAH, the RNs in the ED at IU Health Frankfort were invited to participate in this project. *(Appendix M-Indiana University IRB Approval Letter, Appendix N-University of Alabama in Huntsville IRB Approval Letter)*

Develop the APT.

This team is a multi-disciplinary response team to intervene when an aggressive patient presents in the ED. A standard work process and a debrief tool has been developed to ensure consistency with the team's response to aggressive or violent situations.

Educate the APT and nursing staff.

Education was provided using the electronic education platform (ELMs), in-person small groups with PowerPoint slides, discussion and hands on to identify how to call an APT response, how to enter a flag into the EMR, and how to de-escalate aggressive behaviors.

Implement the APT.

The APT was implemented for a three-month pilot in the ED. With each APT response, the team would pre-huddle and debrief to understand how the process worked and what could be improved.

Obtaining measurements/measuring outcomes.

In this project, the main outcomes measured were:

- RNs improved perception of safety
- Reporting aggressive behaviors/WPV incidents

- Identify aggressive patients in the EMR via a flag

Instrument

The instrument used to assess perception of safety was the American Hospital Association, *Workplace Violence Staff Assessment Survey* (2017). This survey tool is a 17-question survey with Likert scale, open ended, free text, yes/no, and 8 demographic questions were added. *(Appendix-O Tools Used-American Hospital Association-Workplace Violence Staff Assessment Survey and Appendix P-Demographic Questions).*

There is no data available related to reliability and validity. To gain face validity, the survey tool was sent to seven emergency department nurse experts for their input. The results of the face validity indicated that all seven nurses who evaluated the survey, found it was valid for the project. This survey tool has been used by many organizations since it was introduced to the public in 2017. This survey tool is publicly shared by the American Hospital Association on their website. No permission was required as it is readily available by the organization to anyone who would like to use it in their facilities (A. H. Association, 2017).

As an employee of the clinical site, the DNP project leader reduced survey bias by using an established tool that has consistent questions. To reduce overall survey bias, the DNP leader remained objective by having multiple people review and interpret these data, having the results reviewed by the Health and Safety Taskforce members, and verifying these data sources.

For this project, the questions were transferred to Survey Monkey, an online secure platform, and stored on a hospital issued computer that is password protected with two-factor authentication. Electronic surveys contain de-identified data only. Each participant chose their own, unique, 4-digit code to use in both the pre and posttest survey completion. There is no specific identifying data on the survey, such as name, however, gender was one of the

demographic questions. With a small sample size, care was taken to provide anonymity. The list of participants 4-digit codes assisted the project leader in understanding who took the survey pre and post intervention. This list is stored on a hospital computer for one year after the project is complete. IP addresses were not collected. There was no Protected Health Information (PHI) or Health Insurance Portability and Accountability Act (HIPAA) identifiers.

Other tools used by the organization since 2017 include, the Daily Clearsight incident reports, and daily security reports. Staff are encouraged to enter an incident report in the Clearsight incident reporting system any time a potential or actual safety event occurs. As part of the Culture of Patient Safety, staff are encouraged to "see something, say something". These events are shared daily with the leaders in all departments, and the risk manager. The risk manager trends these data monthly. *(Appendix-Q, Incident Reports-Summary 2019)* The manager of the department where the event occurred, takes action on the reported event by gathering facts and, forwarding the incident to the Nursing Peer Review Council, Medical Standards Council, or Safety Event Classification Committee for further review.

Data Collection

Data was collected using several methods: some are already in use, and other new methods were developed for this project. Sources of data collection for this project included the Daily Clearsight incident reports, Daily Security Reports, weekly EMR audits, weekly review of APT calls/debrief tool, and the *Workplace Violence Staff Assessment Survey* pre and post intervention survey results.

Daily Incident Reports and Security Reports.

The incident reports and security reports were reviewed by the CNO/DNP Project Leader, along with the nurse manager and the security supervisor. Data was collected from these

reports daily, and the seven-day mean was generated into a weekly report. This weekly run chart was reviewed for data trends. These data were compared to the baseline data from 2019. With an increased awareness by staff of the problem, it was likely and expected that the reporting of aggressive incidents would increase at the beginning of the project.

Weekly EMR Audit.

A weekly audit in the EMR of aggressive patients' charts was employed to identify if a flag was entered. The patient's chart was flagged in the EMR when the APT responded to an event and the patient was violent or aggressive. These data were plotted on a run chart to establish trends.

Weekly review of APT calls.

Data were collected on the number of times the APT was called. A debrief tool was reviewed by the Health and Safety Taskforce, monthly, to identify trends, such as time of day events occur, days of the week, or personnel involved.

Evaluation

Data was collected and analyzed using pretest and posttest scores on the *Workplace Violence Staff Assessment Survey*. The paired *t*-test was used to understand statistically significant differences between pretest and posttest scores. Along with the survey results, the monitoring of daily incident reports and Safety and Security reports were used to identify if there is an increase or decrease in the reports and the number of patients who the APT intervened on, and number of EMR flags. These data gave the DNP project leader an understanding of how the nurses perceive the practice environment, how and when nurses report incidents and how and when nurses flagged the EMR.

Results

The pre-intervention survey was sent to all fifteen ED nurses. The survey response was 60%, *n*=9 surveys were completed and returned. The post-intervention survey response was 60%, *n*=9 surveys were completed and returned. The data was correlated using IBM Statistical Product and Service Solutions (SPSS) and the paired *t*-test. On the survey, four questions focus on the nurse's perception of safety. The pretest and posttest results were correlated for significance.

Demographic characteristics of survey participants indicate they were primarily female, 88% (*n*=8), and 12% (*n*=1), male and 100% (*n*=9), 22.22% (*n*=2) had been a nurse 1-3 years, 11.11% (*n*=1), had been a nurse 3-5 years, 22.22% (*n*=2), had been a nurse 5-9 years, 11.11% (*n*=1), had been a nurse 15-25 years and 33.33% (*n*=3) had been a nurse for over 25 years. Additionally, all nurses indicated they had worked at Indiana University Health between 1-9 years. Participants indicated their ages between 25-64. All nine participants reported they had personally experienced some form of WPV in the past. Of the nine nurse participants, 88.89% report increased perception of safety in the in ED after the implementation of the APT. *(Figures 1-6, Demographics and WPV Definition and Experience)*

Questions 10, 11, 12, and 13, all focus on the nurse's perception of safety in various areas in the ED. The nurses were asked to rank their level of perceived safety, on a scale of 0-100. Zero, meaning not safe at all to 100, feeling completely safe. The statistical results of each question are below.

Question 10, "Rate how safe you feel from WPV in the ED overall". The mean score on the pretest was 71.89. The mean score on the post test was 76.11. This is an increase of 4.22 in

the mean. Although *sig*= 0.005, (p<0.05) with an N-size of 9, statistical significance cannot be established. *(Table- 2)*

Question 11, "Rate how safe you feel in exams rooms." The mean score on the pretest was 64.78. The mean score on the post test was 69.44. This is an increase of 4.66 in the mean. *(Table-3)*

Question 12, "Rate how safe you feel in the trauma rooms." The mean score on the pretest was 65.67. The mean score on the post test was 71.11. This is an increase of 5.44 in the mean. *(Table-4)*

Question 13, "Rate how safe you feel in the psychiatric room." The mean score on the pretest was 55.67. The mean score on the post test was 66.00. This is an increase of 10.33 in the mean. Although *sig*= 0.007, (p<0.05) with an N-size of 9, statistical significance cannot be established. *(Table-5)*

Question 15 was aimed at understanding the nurse's reporting of WPV. The question asks, "If you have experienced WPV while working at this facility, did you formally report the occurrence(s)? Pretest responses were; 22.22% (n=2), responded "No, I do not formally report the occurrences." 55.56% (n=5) responded "Yes, I formally reported some of the occurrences." And 22.22%, (n=2) responded "Yes, I formally reported any occurrence of WPV." Posttest responses: participants responding "No" were 11% (n=1), 44.44% (n=4) responded "Yes, I formally reported some of the occurrences, and 44.44% (n=4) responded "Yes, I formally reported any occurrence of WPV. *(Figure-7-WPV Reporting)*

Question 22 is aimed at understanding if WPV has increased, decreased or remained the same over the past year. Pretest responses indicate that 55.56 (n=5) feel that WPV has increased, 11.11% (n=1), indicated WPV has decreased, and 33.33% (n=3) indicate that WPV has remained

the same. The posttest responses indicate that 88.89% (n=8) feel that WPV has increased over the past year, while 11.11% (n=1) indicate that WPV has decreased and zero participant indicated that it has remained the same. The majority of nurses completing the posttest, indicate they feel WPV has increased over the past year. *(Figure-8 and 9, WPV Occurrence)* Participants indicate that 100% (n=9) participated in and APT intervention during the pilot timeframe. *(Figure 10-Posttest-Participation in APT)*

Question 25 asks, "Do you feel safer knowing you have the APT as a resource?". The responses were 88.89% (n=8), indicate affirmatively that they feel safer and only 11.11% (n=1) indicate that they do not feel safer. This question supports the intervention of the APT in the ED setting as a way to provide a resource and give nurses the perception of safety. *(Figure-11-Posttest-Perception of Safety)*

Although the sample size was small, and the statistical significance cannot be determined, based on the pretest and posttest means, nurses' perception of safety increased after the implementation of the APT. Additionally, nurses' responses indicate a perception of increased WPV events over the past year, and an increase in reporting WPV. It can be inferred that with the mean score increasing on questions 10, 11, 12, and 13, the nurses' perception of safety did improve after the implementation of the APT.

Incident reports were reviewed on a daily basis to identify situations nurses encounter with violent or aggressive patients. Daily incident reports were compared to the same time last year and found that behavioral events have increased by 100% since 2019. From January 1, 2019 to September 1, 2019 there were 103 behavioral incident reports entered into the incident reporting system. During the same timeframe in 2020, there were 207 behavioral incident reports entered from January 1, 2020- September 1, 2020. Data was collected from the daily incident

reports and plotted on a run chart to identify trends and show the number of event reports during the 90-day pilot. *(Figure 12-Weekly Incident Reports).* Daily Security Reports were reviewed and compared to 2019 data. There has been a significant increase in Safety and Security Reports during the 90-day pilot timeframe. This increase could be in part due to increased awareness of events, however, the data indicates that there are more events related to psychiatric illness, drug overdose, than the same time in 2019. In addition, there have been an increase in physical altercations over the 90-day pilot. *(Figure 13-Security Reports- Comparative Data 2019/2020).* One must also consider the effects of the current pandemic on the increase in behavioral events. In the midst of the pandemic, there have been issues with stress, unemployment, depression and other mental health conditions that could be a correlation to the increased behavioral events.

Weekly review of APT calls/debrief tool shows that there were thirteen (13) APT calls during the 90-day pilot. All thirteen calls resulted in a full response from the APT. The pre-huddle was conducted, the team intervened with the patients, and the post huddle debrief was conducted to understand what went well and what could be improved. Analysis of the APT audit log indicate that there were more calls during the day shift (9), compared to night shift (4). In addition, there were five calls related to overdose, three related to dementia, one seeking drugs, two with psychiatric illness and two others.

Weekly EMR audits showed that a flag was placed on 100 % of charts when the APT was called to intervene. There were thirteen APT calls and responses during the 90-day pilot timeframe and thirteen flags were placed in the EMR. *(Figure-14-Weekly EMR Audit for APT Calls and Flags).*

As the project leader, observations were made on many of the APT responses. During these observations, it was noted that the team began to work more collaboratively with one

another as time went on. Additionally, the team supported the nurses, and the nurses became more proactive in their calls for the APT. One example was a patient who presented with an overdose and was extremely physically aggressive. During this APT response, the security officer was injured. The RN placed documentation in the EMR, including flagging the chart. The same patient presented a week later, having overdosed again, and the team was proactive in their care, to the point of EMS calling ahead, to alert the team of the patients' arrival. The team accessed the patient's chart in the EMR, viewed the notes and flag from the previous visit and were prepared for the patient's arrival, including notifying local police for assistance. This proactive approach allowed the team to be prepared for the patient's arrival, and provide excellent care to the patient and support for the staff.

Conclusions

WPV is a serious problem in healthcare today, with the ED being the most dangerous area in the hospital. By developing and implementing an APT, the incidents of staff injuries, patient aggression and overall violence in the ED can decrease, and will support nursing staff and improve their perception of safety in the workplace. The literature supports the development of such as team to intervene in aggressive patient situations to not only de-escalate the patient, but provide safety and support to the staff. Nurses who care for patients that are aggressive, feel supported by the APT and feel more confident in caring for these patients. Nurse leaders should facilitate effective WPV programs, with interventions, such as developing an APT, and reporting programs to provide nurses with a safe environment to practice. Developing an APT can be applied to all areas of Nursing Practice where care is provided for aggressive or violent patients. This implementation of an APT can be developed into best practice, and EBP protocols for all

nurse leaders to implement in their hospitals. By having a robust violence prevention focus and team, we can affect WPV and decrease the incidents in our hospitals.

Application to Nursing Practice

By developing and implementing an APT, the incidents of staff injuries, patient aggression and overall violence in the ED can decrease; an APT, supports nursing staff and improve their perception of safety in the workplace. Results of this evidence-based quality improvement project support the development of such a team to intervene in aggressive patient situations to not only de-escalate the patient, but provide safety and support to the staff. Nurses who care for patients that become aggressive or violent, feel supported by the APT and feel more confident in caring for these patients.

Recommendations for future studies include, replicating with a larger sample size to determine statistical significance in the paired t-test. The implementation of an APT should be spread across all areas in the hospital. The plan is to spread the APT to all areas of the hospital in early December 2020, and to other hospitals in the System.

As nurse leaders it is imperative, we support the nursing team and provide a safe environment for them to provide patient care. This DNP Project and developing an APT can be applied to all areas of Nursing Practice where care is provided for aggressive or violent patients. This implementation of an APT can be developed into best practice, and EBP protocols for all nurse leaders to implement in their hospitals. By having a robust violence prevention focus and team, we can affect WPV and decrease the incidents in our hospitals. Nurse leaders should facilitate effective WPV interventions, such as developing an APT, and reporting programs to provide nurses with a safe environment to practice.

Sustainability

To sustain this work, it is important to understand the limited staff that are available in the hospital at any given time. The Nursing Supervisor and Security officer are vital in the APT response. The CNO, Nurse Manager and Chaplain will continue to respond when in house. This will provide additional support to staff in these challenging situations. The outcomes of the project indicate that nurses are more comfortable reporting the events, and flagging the charts, which demonstrates additional ways WPV is reported. As with any new process, keeping it at top of mind will help to hardwire the behaviors. Discussing APT at each daily department huddle where events can be discussed, as well as learn what went well and what can be improved. Also, adding education about the APT, documentation and EMR flags to all new staff orientation. Implementing monthly mock drills, will add to the awareness and continue to improve the process.

To better understand the survey tool and gain validity and reliability with the questions, this project can be replicated at the larger Indiana University Health facilities to gain a larger sample size. Currently two regional and one critical access hospital have the APT in place. As the CNO, and being affiliated with all the CNOs across the system, the network of colleagues is strong. The CNOs meet on a weekly basis to discuss current trends and issues in the healthcare environment. This weekly meeting is a platform to share the outcomes of this project and assist with the implementation at all the hospitals. If spread across the System, to the other 14 facilities, this would increase the sample size and provide an opportunity to determine reliability of the survey tool. By spreading this evidence-based intervention to all facilities, this would significantly contribute to the literature.

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APPENDICES

Appendix A- Indiana University Health Frankfort, 2019-Security Data

Indiana University Health

Security End-Year Statistics
June 2019 – December 2019
(Note: High Risk Patient Tracking Began in June)

June: Total Calls – 134
High Risk Patients – 30
Percent of Calls High Risk – 22%

July: Total Calls – 161
High Risk Patients – 25
Percent of Calls High Risk – 15%

August: Total Calls – 167
High Risk Patients – 35
Percent of Calls High Risk – 21%

September: Total Calls – 150
High Risk Patients – 38
Percent of Calls High Risk – 25%

October: Total Calls – 152
High Risk Patients – 54
Percent of High Risk Patients – 35%

November: Total Calls – 144
High Risk Patients – 54
Percent of High Risk Patients – 38%

December: Total Calls – 159
High Risk Patients – 33
Percent of High Risk Patients – 21%

Total Calls from June to December 2019: 1,067
Total Number of High Risk Patients June to December 2019: 269
Percentage of High Risk Patients from June to December 2019: 25%

Some of the numbers include patients from Inpatient Units Calls - Not all ED Patients
Year End Stats include limited Data from January to June
Confidential, for internal use only

iuhealth.org

Total Searches Performed: 231
Total Consented Performed: 230
Consented Percentage: 99.5%
Missed Searches: 63
Missed Percentage: 27%
Search Percentage with No Find: 78%
Search Locating a Weapon: 5%
Search Locating Tools: 1%
Search Locating Drugs: 5%
Search Locating Paraphernalia: 5%
Search Locating Prescription Drugs: 6%

Total SI Patients: 81
Percent of High Risk: 29%
Total OD/Alcohol Patients: 63
Percent of High Risk: 23%
Total Law Enforcement Clearance Patients: 72
Percent of High Risk: 26%
Total Inmate Patients: 31
Percent of High Risk Patients: 11%
Total Acting Out/Suspicious Patients: 29
Percent of High Risk Patients: 11%

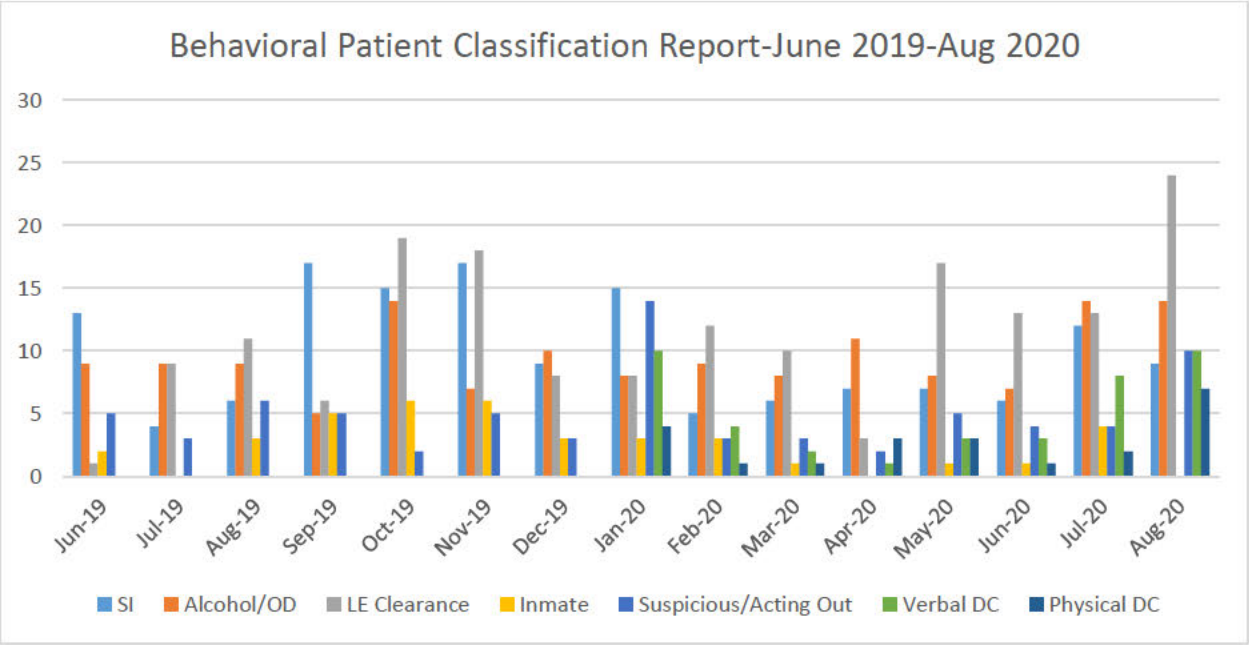
Total High Risk Patient Reported to Security: 241
Not Reported High Risk Patients: 28
Percent of High Risk Reported to Security: 85%

Percentage ED Registration Reported High Risk Patient: 41%
Percentage ED Staff Reported High Risk Patients: 32%
Percentage Officer Self-Reported High Risk Patient: 19%
Percentage of No Report Presented High Risk Patient: 9%

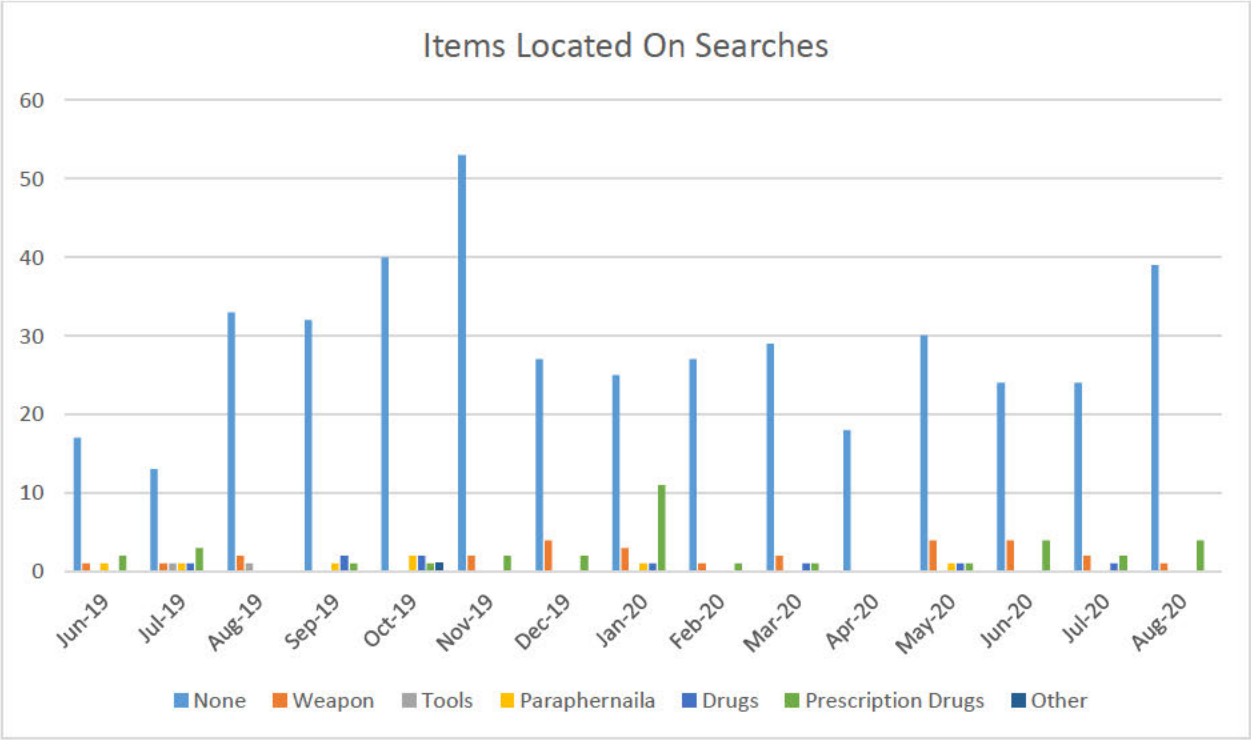
Average Calls for Service per Day for 2019: 4 Calls a Day
Average Calls for Service per Week for 2019: 29 Calls a Week
Average Calls for Service per Month for 2019: 116 Calls a Month
(This data includes tracked information for entire 2019)

Some of the numbers include patients from Inpatient Units Calls - Not all ED Patients
Year End Stats include limited Data from January to June
Confidential, for internal use only

Appendix B- Security Events-Behavioral Events 2019/2020



Appendix C- Security Searches Summary-2019



Appendix D- Patient and Visitor Policy

Current Status: *Active* PolicyStat ID: *6259971*

Origination:	*07/2019*
Effective:	*07/2019*
Last Approved:	*07/2019*
Last Revised:	*07/2019*
Next Review:	*07/2020*
Owner:	*Wesley Hickson: Supv-Prot Svcs*
Area:	*Administrative*
Tag:	
Applicability:	*Indiana University Health Frankfort*

Frankfort

Patient / Visitor Behavior

I. PURPOSE:

Indiana University Health has a duty to provide a safe and secure environment for employees. Physical and/or non-physical assault by a patient or visitor will not be tolerated and decisive action will be taken to protect staff. Indiana University Health is committed to minimize both physical and non-physical assault against staff and professionals who work in or provide services at Indiana University Health.

II. SCOPE:

This policy has been developed to give clear guidelines to all employees of actions to be taken in the event of physical or non-physical assault to staff and professionals who work in or provide services at Indiana University Health including contracted patient care providers.

III. EXCEPTIONS:

None

IV. DEFINITIONS:

Non-Physical Assault/Unacceptable Behavior: The use of inappropriate words or behavior causing distress and/or constituting harassment. Examples include:

- Excessive noise, e.g. loud or intrusive conversation or shouting.
- Malicious allegations relating to members of staff, other patients or visitors.
- Offensive sexual gestures or behaviors.
- Abusing alcohol or drugs in hospital. (However, all medically identified substance abuse problems will be treated appropriately.)
- Non-prescribed drug use or drug dealing
- Willful damage to Indiana University Health property
- Theft

Physical Assault/Violent Behavior: The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort. This type of assault/behavior also includes behavior jeopardizing the immediate physical safety of the patient, staff or other individuals within the patient's proximity. These situations typically involve rage, anger, outbursts, screaming, etc. Examples include: acting physically aggressive toward others by lunging, throwing furniture, using furniture as a weapon, using

furniture to break windows, punching walls, etc.

Unintentional Assault/Behavior: behavior that has the potential to cause *unintentional harm* (not suicidal or intentionally harming oneself) to the person exhibiting the behavior but does not represent a threat to the safety of other individuals within the patient's proximity. This behavior is often described as confused, disoriented, unable to participate in care plan, etc. Some causes include sedation medications, head injuries, delayed developmental age or decreased cognitive ability, etc. Examples include:

- A patient with a critically high INR persistently pulls at tubes or lines despite attempts to redirect, cover lines, explain safety risks to patient, etc. ? The same patient also has a fresh hip replacement and constantly attempts to get out of bed, is unable to use the call light or use safety devices like a walker

V. POLICY STATEMENTS:

The mission of Indiana University Health is to improve the health of our patients and community through innovation and excellence in care, education, research and service. Collaboration for healing between patients, families and staff must be the primary objective. It must be acknowledged that aggressive and or undesirable behavior is an impediment to collaboration and healing. Prevention of the circumstances leading up to aggressive or undesirable behavior should be the first goal, followed by efforts to respond to and deescalate aggressive and undesirable behavior. It is recognized however, that on occasion prevention will not be possible as frequently the behavior is pathological in nature and requires professional, expert intervention.

As a method to strengthen the patient's body, mind, and spirit, the initiation of all Indiana University Health resources (Chaplaincy, Physicians, Leadership, Security etc) to deescalate a behavioral issue should be the priority.

All staff involved in incidents will receive the full support of their managers where action has been taken in good faith for the benefit and safety of the patients, visitors, and staff.

VI. PROCEDURES:

A. Initial Response

1. As soon as safely possible (and not within hearing distance of the aggressor), notify Safety and Security.
2. Remain calm; acknowledge the patient's or visitor's concerns. Do not attempt to make sense of the behavior or reason with the aggressor.
3. Stimulation reduction is the primary goal of de-escalation; speak with a low-tone voice and demonstrate respect.
4. Ask what can be done to help. Do not impose ideas to the aggressor.
5. Giving the aggressor undivided attention, validation and listening to concerns are essential to diffuse aggressive behavior.
6. Make eye contact, do not smile or appear defensive (crossed arms or have an object of perceived threat in hand)
7. Keep your distance - place yourself in a position which allows you to escape. Never allow the aggressor to be positioned between you and the door.
8. Remove items likely to cause injury – watches, pens, glasses and ties – out of sight of the patient / aggressor.

9. Describe the situation as a physical assault/violent behavior or non-physical assault/unacceptable behavior.
    a. Physical Assault/Violent Behavior: Security will respond immediately to the location of the violence. The IU Health Security Officer will assist the staff member, visitor, or other patient during the completion of the police report in the event that charges will be filed.
    b. Non-Physical Assault/Unacceptable behavior: IU Health Security will initiate the APT (Aggression Prevention Team)
10. Prevent others from threatening the patient/aggressor. Never attempt to detain the aggressor without Police/Protective Services presence.

B. Aggression Prevention Team Response
    1. Upon notification from IU Health Security, a front line response to evaluate the non-physical assault, violent behavior, and/or unacceptable behavior. The initial response will be:
        a. Associate Administrator
            i. Front line response.
        b. Security
            i. Support Associate Administrator in response to incident
        c. Department leadership or designee
            i. Support Associate Administrator and security as needed.
    2. Following any incident, the Clinical Manager (or their designee) will notify the patient's attending provider and a plan for subsequent behavior violation will be established and documented in the patient's medical record.
    3. Security will explain to the patient or visitor that his/her behavior is unacceptable and explain the expected standards that must be observed in the future. The incident and warning should be recorded and reported in the medical record by the staff member involved and any witnesses (including incidents involving a patient's visitor).

C. Implementation of a Care Contract
    1. Failure of the patient or visitor to subsequently desist inappropriate behavior will result in the application of a Care Contract for individuals who physically and/or non-physically assault staff as a formal written warning of the consequences of such behaviors.
    2. The terms of the Care Contract will be developed by the patient's attending provider, Clinical Manager, and security, with support from Chaplaincy and the legal department as appropriate. Terms of the contract should include:
        a. All patient demographic information or visitor access points
        b. Identified behavior violations
        c. Consequences of future violations: Patient
            i. Restrictions of amenities/privileges (movement off of unit, visitors, television, telephone)
            ii. Institution of discharge procedures
            iii. Inclusion of law enforcement support
        d. Consequences of future violations: Visitor

i. Restriction of visiting privileges

ii. Admonishment of subsequent visitation

D. The patient's Care Contract is entered into the Cerner system as a permanent chart document. The visitor Care Contract will be maintained by the IU Health Security department. The duration of all Care Contracts will be one year.

E. In the case of repeated physical violence and/or noncompliance with documented Care Contracts, the patient will not be eligible for inpatient/outpatient health provisions from Indiana University Health. Such exclusion will last one year, subject to alternative care arrangements being made. The provision of such arrangements will be pursued with vigor by the patient's attending provider, hospitalist, and nursing departmental support. In the event of an excluded individual presenting at an Indiana University Health Emergency Department or Outpatient Clinic for treatment, the individual will be treated and stabilized with, if necessary, police/protective services staff in attendance. Where possible, the patient would then be transferred immediately to a facility capable of providing the needed level of care. However, if admission is unavoidable security staff will, if necessary, remain in attendance.

F. If the Attending Physician determines a returning offender's only option is admission to an Indiana University Health facility, the existing Care Contract restrictions resume on admission.

VII. CROSS REFERENCES:

Visitation
Patient Off-Unit Privileges

VIII. REFERENCES/CITATIONS:

None **Forms/Appendices:** None

IX. RESPONSIBILITY:

Police/Protective Services & Risk Management

X. APPROVAL BODY:

Police/Protective Services & Risk Management

XI. APPROVAL SIGNATURES:

Approved By:

IU Health Frankfort President

Chief Nursing Officer

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Sign	Marilyn Riley: Chief Nursing Officer	07/2019

Step Description	Approver	Date
Sign	Kelly Braverman: President-IUH Frankfort	07/2019
Vet	Brianna Lerch: Project Coordinator	07/2019
Editor	Sean Kuyper: Mgr-Quality & Infect Prevent	06/2019
	Wesley Hickson: Supv-Prot Svcs	06/2019

Applicability

Indiana University Health Frankfort

Appendix E- Health and Safety Taskforce Charter and Goals, 2019 and 2020

Health and Safety Taskforce: Subcommittee of Safety Committee- Charter-2019

- Purpose
  - Establish consistency in caring for patients and family members with aggressive or violent behaviors.
  - Commit to making decisions based on evidence-based practice
  - Create best practices for effective teamwork and collaboration with nursing team and other disciplines
  - Utilize standards of practice as outlined in regulatory entities such as: The Joint Commission, National Patient Safety Goals, AACN Healthy Workplace guidelines, etc.

- Members
  - Chair & Co-Chair: Wes Hickson and Justin Reagin
  - Facilitator: Sean Kuyper and Marilyn Riley
  - Members: Clinical Nurses/ Safety and Security, Cardiopulmonary
    - Sean Kuyper, Wes Hickson
    - Med-Surg: Nora Thatcher, RN
    - ED: Jona Metro, RN/Becca Sietsma, RN
    - Education: Kami Young, RN
    - Cardiopulmonary: TBD
    - Associate Administrator- Michele Tansey
    - Facilities: Steven Parker
    - Chaplain: Ken Rushing

- Meeting Structure
  - Monthly face to face meeting at Frankfort- Meet First Tuesday of each month at 1000- Med Surg Conference Room/WebEx

  - Executive Support
  - Marilyn Riley CNO-Clinical
  - Kelly Braverman- President

1

Health and Safety Taskforce: Subcommittee of Safety Committee- Charter-2019

- Goals
  - Develop standardized workflow and decrease care variation that enable staff to practice in a safe environment
  - Develop a response team/code mechanism (i.e.. Dr Armstrong, APT)
  - Coordinate education for staff
    - Mock drills, overhead alerts or panic buttons, encourage reporting of aggressive behaviors, other education as identified
  - Incorporate System policy- Harassment and Workplace Violence (HR-147)
  - Update and edit Patient/Visitor Behavior Policy from IU North
  - Conduct Risk Assessment and Gap Analysis
  - Review Safety/Incident reports including violent behaviors
  - Develop Transition Plan to new building

2

Charter- Health and Safety Taskforce 2020

- Purpose
  - Establish consistency in caring for patients and family members with aggressive or violent behaviors.
  - Commit to making decisions based on evidence-based practice
  - Create best practices for effective teamwork and collaboration with nursing team and other disciplines
  - Utilize standards of practice as outlined in regulatory entities such as: The Joint Commission, National Patient Safety Goals, AACN Healthy Workplace guidelines, etc.

- Members
  - Chair & Co-Chair: Wes Hickson and TBD
  - Facilitator: TBD and Marilyn Riley
  - Members: Clinical Nurses/ Safety and Security, Cardiopulmonary
    - Wes Hickson
    - Med-Surg: Nora Thatcher, RN
    - ED: Jona Metro, RN/Becca Sietsma, RN
    - Education: Kami Young, RN
    - Cardiopulmonary: TBD
    - Associate Administrator- Michele Tansey/TBD
    - Facilities: Steven Parker
    - Chaplain: Ken Rushing
    - SPA-Teri Johnson

- Meeting Structure
  - Monthly face to face meeting at Frankfort- Meet First Tuesday of each month at 1000- Med Surg Conference Room/WebEx

  - Executive Support
  - Marilyn Riley CNO-Clinical
  - Kelly Braverman- President

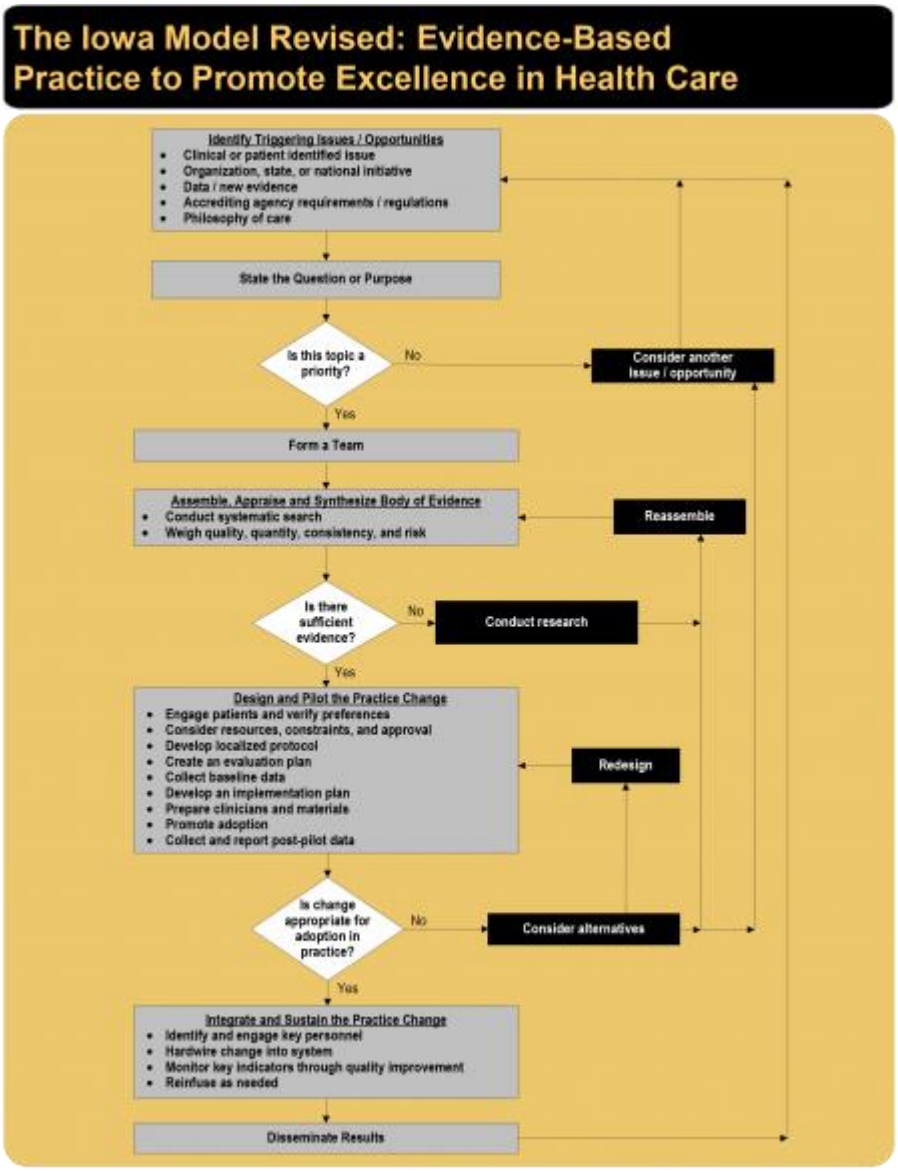
1

Health and Safety Taskforce- Charter 2020

- Goals 2020
  - Develop standardized workflow and decrease care variation that enable staff to practice in a safe environment
  - Develop a response team/code mechanism (i.e.. Dr Armstrong, APT)
  - Develop standard work for APT
  - Develop debrief tool for APT
  - Coordinate education for staff
    - Mock drills, overhead alerts or panic buttons, encourage reporting of aggressive behaviors, other education as identified
    - Monthly Crisis Avoidance Training for all employees and annual refresher
  - Review Monthly Safety/Incident reports including violent behaviors
  - Develop Transition Plan to new building

2

Appendix F- Iowa Model Diagram



Appendix G- Email sent to participants

Dear IU Health Frankfort ED Registered Nurses, June 1, 2020

As you many of you know, I am pursuing my Doctor of Nursing Practice. As part of that coursework, I am implementing a Quality Improvement project in the ED. The project is related to violent patients in the ED. This project was developed in an effort to reduce violence in the ED and maintain a safe working environment for you.

I ask that you take this 15-question survey to help understand the violent situations you encounter, as well as the perception of safety in your work environment. This survey will take 20-30 minutes to complete. There are no expected risks associated with your participation. Results of this study can benefit nursing by better understanding the perceptions of RNs in the ED when faced with aggressive patients. This will inform the body of nursing knowledge and have a potential impact on other organizations and nursing as a profession to address the growing issue of workplace violence. This could have a potentially positive outcome on nursing related to decreasing burnout, compassion fatigue and providing evidence-based nursing care to patients with aggressive behaviors.

There are no incentives or compensation for your participation.

The results of the survey responses are available only to the researchers directly involved in the study, thereby, ensuring strict confidentiality. The data from this survey will be identified only using your 4-digit participant number.

You may withdraw from the study at any time. You will not be penalized if you withdraw. Investigators reserve the right to remove any participant from the session without regard to the participant's consent.

Your participation in the survey is completely anonymous and voluntary. Your consent to participate is implied with the completion of the survey.

I ask that you complete the survey by clicking on the link below.

(survey monkey link)

Once the survey responses are complete, the study intervention will be the implementation of an Aggression Prevention Team. This team will be established to intervene when patients become violent in the ED. Education will be provided to the staff in the ED related to the APT, when to call, how the team intervenes and then you will be asked to participate in a post-intervention survey.

If you have any questions, please contact Marilyn Riley at mriley6@iuhelath.org.
If you have questions about your rights as a research participant, or concerns or complaints about the research, you may contact the Office of the IRB at 256.824.6992 or email the IRB chair Dr. Ann Bianchi at irb.@uah.edu.
This study was approved by the Institutional Review Board at UAH and will expire in one year from May 23, 2020.

Thank you for your participation in the survey.

Sincerely,
Marilyn Riley

Appendix H- Education PowerPoint

Learning Objectives

Learners will:

1. Understand who the Aggression Prevention Team (APT) is and what to expect
2. Discern when to initiate an APT intervention
3. Verbalize how to initiate an APT intervention
4. Understand the process surrounding APT intervention

200%

Violence in the healthcare setting has increased by 200% since 2003.

46%

46% of healthcare workers experienced violence during one of the last five shifts worked.

5 times

Health professionals are assaulted at a rate 5 times greater than all other occupations combined.

100%

Indiana University Health wants to keep staff and patients safe 100% of the time.

Strategic Plan for Improvement

- Goal
  - *Caregivers need to feel safe and supported while providing care to patients*
- Current state analyzed and ideal state included a rapid response team that responded to the threat of violence
  - *Aggressive Prevention Team*
- Inter-professional team included clinical and non-clinical services
- Evaluation process for effectiveness

Tiered Approach to Safety

- Prevention
  - ❑ Early recognition of grievance
  - ❑ Meet the patient's needs
  - ❑ De-escalation techniques

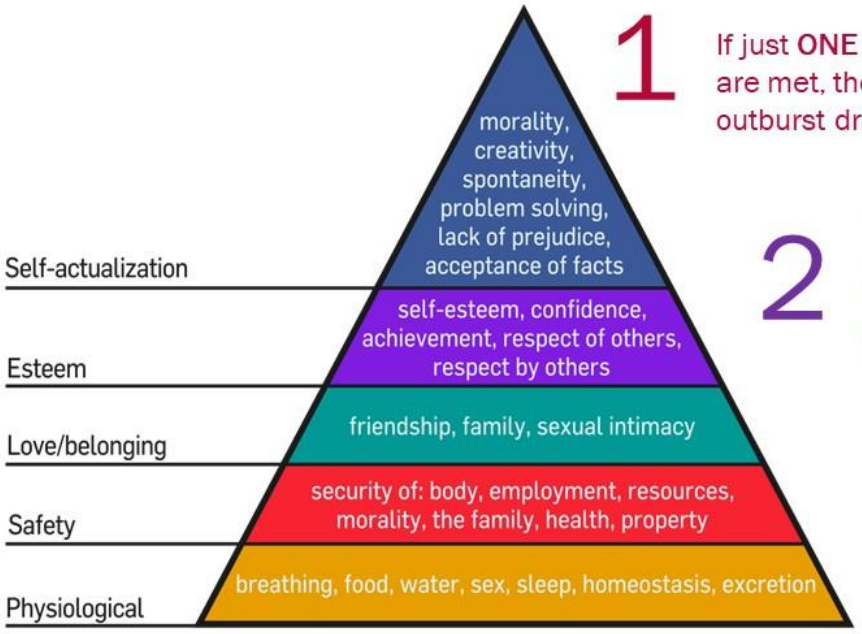
- Response
  - ❑ Aggression Prevention Team – APT -Escalating conduct

- Recovery
  - ❑ RISE Team Member Support
  - ❑ Employee Assistance Program for individual counseling - EAP

Prevention

Recognize and take advantage of opportunities to stop situations from escalating before they get out of hand.

Maslow's Hierarchy of Needs

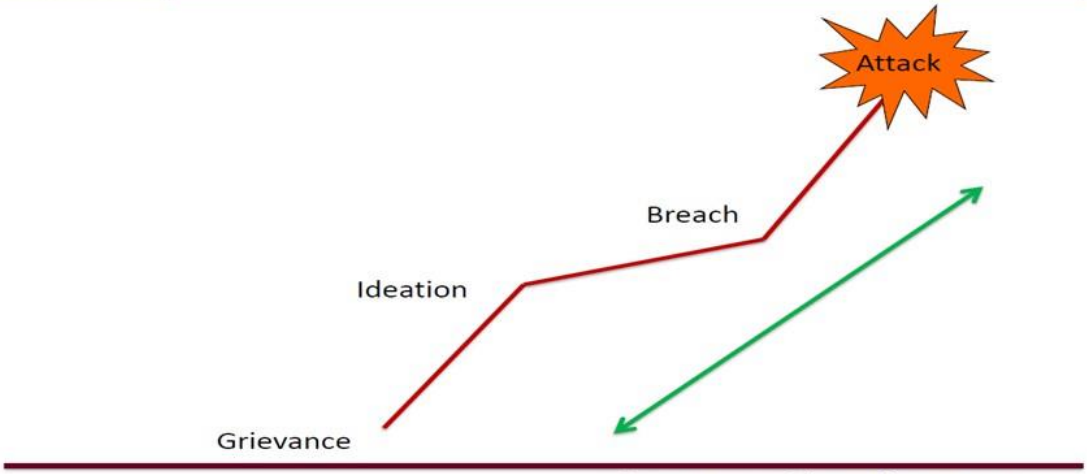


1 If just **ONE** of the basic needs are met, the chance of a violent outburst drops by 50%.

2 If **TWO** of the basic needs are met, the chance of a violent outburst drops by 70%.

Type of Violence - Affective

Pathway to Violence: Affective



Contemporary Threat Management
Calhoun and Weston, 2003

Response

When you can't seem to stop the situation from escalating...

Overview of APT

What:	Aggression Prevention Team (APT)
Why:	Staff initiated action to avert aggressive patient behavior
Who:	Security, AA, Chaplain, Unit Manager, Clinical RN, responding as a team
Where:	Emergency Department
When:	A patient or family member is becoming increasingly agitated or aggressive toward staff.

When to Initiate an APT

- Continued threat to staff by patient or family
- Overt cursing at staff (remember some people's vocabulary just includes cursing)
- Unauthorized video taping or taking pictures of staff while providing care
- Interfering or disruptive behavior by patient, family or visitors
- Anytime staff feel they need additional support

How can you call APT?

1. Call the operator at
2. Request an APT: Specifically ask for an APT
3. State the unit, room number, and the behavior that you see
4. Unit Manager and the Chaplain will only be notified when in house.
5. An overhead announcement WILL be made stating: "*Behavior Alert, APT (Unit location)"*

Aggression Prevention Team

Team includes:

1. Associate Administrator - 24/7
2. Security Officer - 24/7
3. Clinical RN - 24/7
4. Team Member that Initiated APT – 24/7
5. Chaplain, when available
6. Unit Manager, when available
7. Facilities, when available

APT Response

- Response within **5 minutes**
- **PRE-HUDDLE:** Upon arrival reporting team member, AA, Security, RN, Unit Manager and Chaplain receive brief update of current issues/concern from team member point of view.
- Security to stabilize situation if APT in regards to drug use or assault.
- AA/Unit Manager to listen to the patient's explanation of the situation to gain their perspective.
- AA/Unit Manager to build rapport and assess orientation to determine if person is aware of actions and course of action required.

APT Response (cont'd)

- AA/Unit Manager to discuss team member's view of inappropriate behavior and set boundaries.
- If patient is understanding/cooperative, provide verbal warning.
- If patient fails to accept fault, blatantly plans to break rules, is uncooperative or physically assaultive – further action to be determined by AA/Unit Manager. May result in care contract.
- If intervention is inappropriate (dementia, delirium, intoxication, etc.), discuss with RN and/or MD for strategy to remedy behavior.

For your safety…

- ✓ Remain calm and acknowledge the concern.
- ✓ Do not attempt to make sense of the oppositional behavior or reason with the aggressor.
- ✓ Remain at a safe distance from the aggressor and exit emergently if needed.
- ✓ Stimulation reduction is the primary goal of de-escalation; speak with a low-tone voice and demonstrate respect.
- ✓ Ask what can be done to help. Do not impose ideas to the aggressor.
- ✓ Giving the aggressor undivided attention, validation, and listening to concerns is essential to diffuse aggressive behavior.
- ✓ Make eye contact, do not smile or appear defensive (crossed arms or have an object of perceived threat in hand).
- ✓ Never allow the aggressor to be positioned between you and the door.
- ✓ Remove items likely to cause injury - watches, pens, glasses and ties - out of sight of the patient/aggressor.
- ✓ Prevent others from threatening the patient/aggressor. Never attempt to detain the aggressor without Safety & Security presence.

Documentation

Document all inappropriate patient behaviors leading up to and at the time of the event!

-Behaviors preceding the event that escalates to an APT should be documented objectively as a significant event.

-Enter event in the Clearsight Reporting system.

-Once an APT has been declared document in the behavior in the "threatening behavior" note.

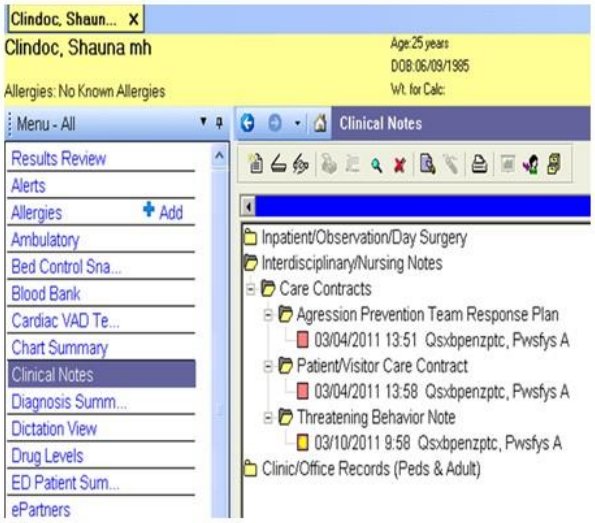
If initiating a Care Contract- document in EMR (Cerner)

Documentation

What should I document regarding an APT?

- All inappropriate behavior should be documented as a significant event note.
- Patient/Family Behaviors
- Interventions used to keep the patient safe
- Assessment done to determine cause/physiologic factors
- Provider notification
- Goal is to keep staff and patients safe, but also to document situations that may put our staff and IU Health at risk
- Care plan modification to reflect behavior/restraint usage

Documentation
Threatening Behavior Note



Found in: Interdisciplinary/Nursing Notes >Aggressive Behavior Records > Threatening Behavior Note.

Documentation is completed at the time of the APT Incident. Team will decide who completes this documentation at the time of the huddle.

Documentation incudes the nature of the incident, assessment, intervention, and recommendations.

Documentation remains in the medical record for future healthcare providers to understand the history of unacceptable behaviors.

The Patient/Visitor Care Contract

Will be completed by AA or Clinical RN.

Possible reasons a Patient / Visitor Care Contract would be initiated:

- Physical and/or non-physical assault by a patient or visitor nor unauthorized patient movement will be tolerated
- Verbal abuse/assault
- Physical abuse/assault
- Non-compliance/refusal of care
- Leaving unit while fall risk or while being monitored
- Leaving unit with medical device
- Possession of firearms or illegal drugs
- Intentional damage to property or theft

Possible Outcomes of Care Contract

For Patients:

- Restrictions of amenities/privileges (movement off of the unit, visitors, television, telephone)
- List restrictions on Care Contract
- Immediate discharge or transfer planning
- Involvement of law enforcement and/or criminal prosecution
- For repeated behavior violations, patient may not be eligible for non-emergent inpatient/outpatient health care services from IU Health facilities for a period of up to one year.

For Visitors:

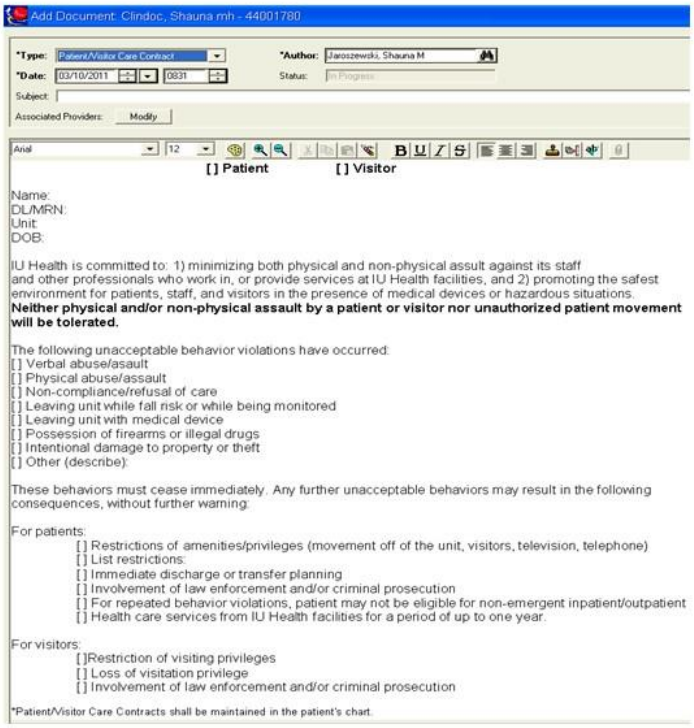
- Restriction of visiting privileges
- Loss of visitation privilege
- Involvement of law enforcement and/or criminal prosecution

***Patient/Visitor Care Contracts shall be maintained in the patient's chart.**

Most Common Boundaries

- Removal of Television
- Removal of Hospital Phone
- Removal of Cell Phone/Tablet/ Laptop –if that item is causing behavior issues (videotaping-repeatedly calling 911) Security will erase video/pictures and lock in cabinet in patient room for period of time
- Limited Menu (no snacks-must order off ordered menu only)
- No Visitors
- Specific Visitor Restriction (for example - mom may not visit)
- Visitor must leave for the evening
- Confiscation by security of paraphernalia/room searched/ articles seized (weapons/drugs/nicotine)
- Must remain in hospital room
- Must remain on floor
- Patient moved to a different room/unit
- Patient/Visitor must speak with Security and or SW prior to visitors reinstated
- Removal of musical instruments or objects sent home with relative.
- Inability to be accepted by hospitalist service if repeated AMA/noncompliance issue at d/c

Documentation
Patient/Visitor Care Contract



Add Document: Clindoc, Shauna mh - 44001780

*Type: Patient/Visitor Care Contract *Author: Jaroszewski, Shauna M
*Date: 03/10/2011 0831 Status: In Progress
Subject:
Associated Providers: Modify

Arial 12

[ ] Patient [ ] Visitor

Name:
DL/MRN:
Unit:
DOB:

IU Health is committed to: 1) minimizing both physical and non-physical assult against its staff and other professionals who work in, or provide services at IU Health facilities, and 2) promoting the safest environment for patients, staff, and visitors in the presence of medical devices or hazardous situations.
Neither physical and/or non-physical assault by a patient or visitor nor unauthorized patient movement will be tolerated.

The following unacceptable behavior violations have occurred:
[ ] Verbal abuse/asault
[ ] Physical abuse/assault
[ ] Non-compliance/refusal of care
[ ] Leaving unit while fall risk or while being monitored
[ ] Leaving unit with medical device
[ ] Possession of firearms or illegal drugs
[ ] Intentional damage to property or theft
[ ] Other (describe):

These behaviors must cease immediately. Any further unacceptable behaviors may result in the following consequences, without further warning:

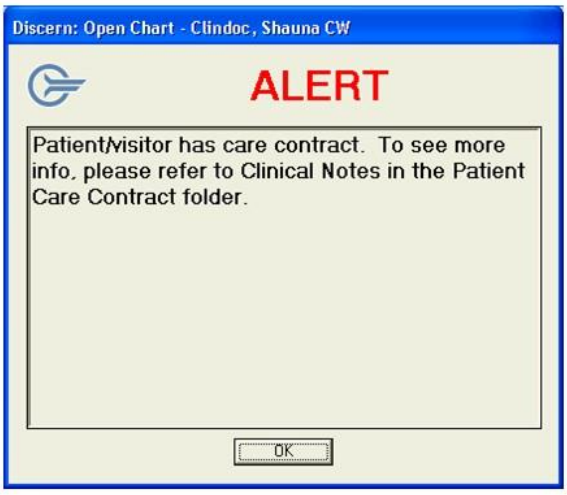
For patients:
[ ] Restrictions of amenities/privileges (movement off of the unit, visitors, television, telephone)
[ ] List restrictions:
[ ] Immediate discharge or transfer planning
[ ] Involvement of law enforcement and/or criminal prosecution
[ ] For repeated behavior violations, patient may not be eligible for non-emergent inpatient/outpatient
[ ] Health care services from IU Health facilities for a period of up to one year.

For visitors:
[ ]Restriction of visiting privileges
[ ] Loss of visitation privilege
[ ] Involvement of law enforcement and/or criminal prosecution

*Patient/Visitor Care Contracts shall be maintained in the patient's chart.

- Documentation can be used for patients and visitors
- Documentation can be customized for the specific behaviors
- Permanent chart document
- Describes unacceptable behavior
- Describe graduated levels of consequences
- Contract outlines expectations and is valid for 365 days
- Contract can be used preventatively when high-risk behaviors are noted through assessment
- Stimulates an automated alert for 365 days

Documentation
Care Contract Alert



- Fires in Cerner so that the alert is available for both outpatient and inpatient providers
- Fires automatically when provider accesses the chart for the first time during any future encounter
- Will stop alerting after 365 consecutive days

APT Debrief

The Charge RN will complete the APT Debrief form and email to Marilyn Riley. The original will be submitted to the Unit Manager.

Aggression Prevention Team Pre-Post Debriefing

Date: _____
Time: _____
Unit: _____
Room: _____

Responders	Reason for the APT	Interventions	Notification/ Documentation	Staff Injury/Harm Continued Support
Who called the APT: _____ Primary RN Caring for the Patient: _____ AA Arrival Time: _____ SW Arrival Time: _____	**PRE-HUDDLE** Precipitating Events _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	☐ Medication ☐ Restraints ☐ AMA ☐ Verbal De-escalation ☐ EDO ☐ Close	☐ Incident Report ☐ SW/AA APT Documentation in Cerner ☐ Care Contract Name of MD Notified	Employee Injury ☐ Intentional ☐ Not Intentional ☐ Employee Injury Report ☐ Medical care Needed ☐ EAP Referral

Thank you

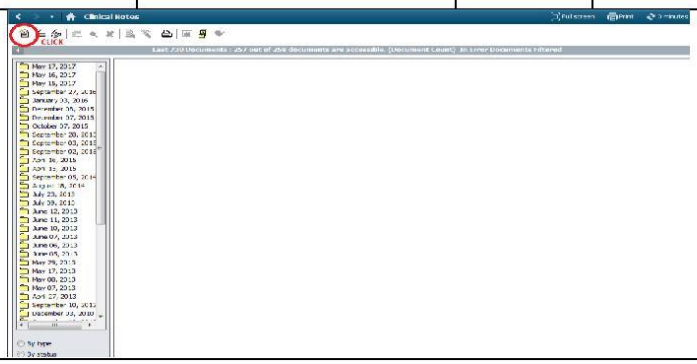
Thank you for taking the time to learn about and Aggression Prevention Team !

Appendix I- APT Standard work- Nursing Supervisor

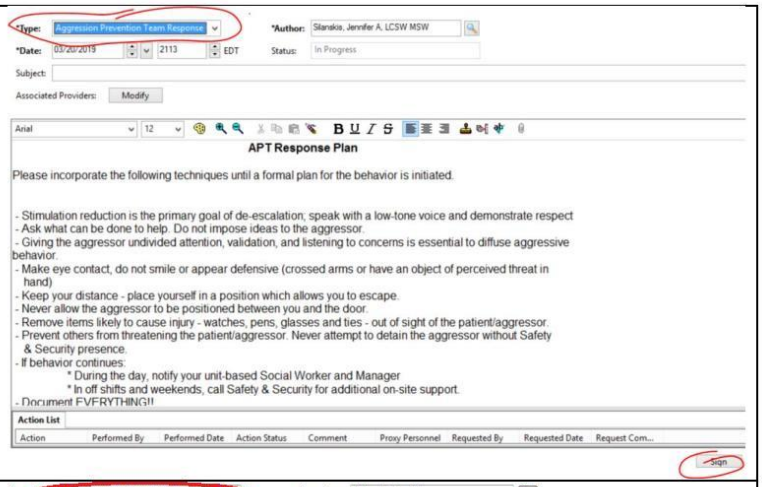
Indiana University Health	**Standard Work Sheet**
PURPOSE: AGGRESSIVE PREVENTION TEAM RESPONSE	**PROCESS:** APT – NURSING SUPERVISOR AND SECURITY
REVIEW DATE 3/27/2020	**DOCUMENT OWNER:** MARILYN RILEY

Step	Description	Key Point / Image / Reason	Who	Time
1	Respond to APT overhead page	Respond within 10 minutes	APT Members, RN, Nursing Supervisor, Security, Unit Manager, Chaplain, Facilities	10 min
2	Receive brief update of current issue/concerns from RN	Allows the team to have full understanding of concerns from nurses point of view.	Full Team	5-10min
3	If APT is in regards to drug use in room or with active assault- allow Security to initiate assessment.	Security to stabilize situation to assure patient and staff safety	Security	5min
4	When reasonable safety is insured Introduce self and role to patient (and/or family).	Build rapport	Nursing Supervisor	5min
5	Assess orientation- Do you know why you are in the hospital? Do you know why we were called?	Determines if patient is aware of actions and if appropriate to proceed with conversation including warning, intervention, and/or Care Contract	Nursing Supervisor	15min
6	Discuss RN's view of events with patient and obtain patient's version	Remain objective to assess how best to address behavior	Nursing Supervisor	10min
7	Explain why this behavior is inappropriate (respect, policy, unit rules/expectations, etc...)	Set boundaries	Nursing Supervisor	10min
8	If patient is understanding and cooperative- provide a verbal warning should behavior continue	Care Contract does not have to be activated at this time unless deemed necessary.	Nursing Supervisor	5min
9	If patient fails to accept fault, blatantly plans to break rules, and is uncooperative and physically assaultive- activate Care Contract and enforce restrictions if necessary.	Patient can refuse to sign the contract –contract is still valid regardless of patient willingness to sign	Nursing Supervisor	5min

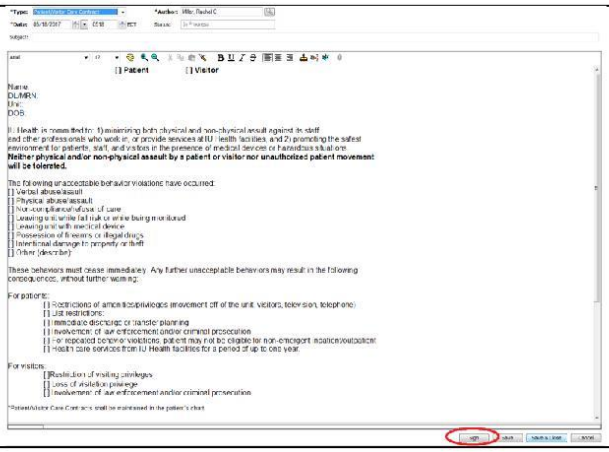
Indiana University Health	**Standard Work Sheet**
PURPOSE: **AGGRESSIVE PREVENTION TEAM RESPONSE**	**PROCESS:** **APT – NURSING SUPERVISOR AND SECURITY**
REVIEW DATE 3/27/2020	**DOCUMENT OWNER: MARILYN RILEY**

10	If patient is inappropriate for a Care Contract- discuss with RN and/or MD strategy to remedy behavior	Not every situation is Care Contract appropriate. Use clinical knowledge to and the multidisciplinary team to decide when appropriate.	Nursing Supervisor	5min
11	If patient presents with an active Care Contract and continues to violate rules and expectations, enforce the contract.		Nursing Supervisor	5min
12	If patient presents with an active Care Contract from the past year, but this is the first social work interaction with the patient during current hospitalization- 1 warning may be appropriate depending on reason for APT.		Nursing Supervisor	5min
13	RN completes APT Debrief Form and email to Marilyn Riley and provide original to Unit Manager		RN/ Nursing Supervisor	5 min
	<u>Nursing Supervisor Documentation</u>			
1	View Clinical notes in Cerner and click on the first image near the dated folders that looks like a page with a star on the corner. The Clinical Notes section is where you will find all three note types that are used for APT documentation.			

Indiana University Health	**Standard Work Sheet**
PURPOSE: **AGGRESSIVE PREVENTION TEAM RESPONSE**	**PROCESS:** **APT – NURSING SUPERVISOR AND SECURITY**
REVIEW DATE 3/27/2020	**DOCUMENT OWNER: MARILYN RILEY**

2	The first note to complete is the 'Aggression Prevention Team Response' note. This note is a template that you don't make any changes to. Just select and sign.	
3	Now- Select 'Threatening Behavior Note' from the drop down menu within Clinical Notes. This is a narrative note that is used to explain the reason the APT was called, the intervention the team decided on, and an explanation of how that intervention was carried out, including patient/family response. Select Sign when complete.	
4	If Care Contract-Flag is being activated: Select 'Patient/Visitor Care Contract' from the drop down in clinical notes.	

Indiana University Health	**Standard Work Sheet**
PURPOSE: **AGGRESSIVE PREVENTION TEAM RESPONSE**	**PROCESS:** **APT – NURSING SUPERVISOR AND SECURITY**
REVIEW DATE 3/27/2020	**DOCUMENT OWNER: MARILYN RILEY**

5	Fill out appropriate information. You are able to delete unnecessary information from the template and also add in additional information that is relevant to the Care Contract process. Sign when complete.	
6	Print Contract	
7	Have patient/visitor sign contract	They may not sign, and that is okay. It can still be activated. You can just offer them a copy.
8	Have medical records scan signed contract in the patient's chart if the patient was willing to sign.	

Appendix J- APT Call Tree- Process for calling APT

Indiana University Health	**Standard Work Sheet**
PURPOSE: **SWITCHBOARD OPERATOR RESPONSE TO APT (AGGRESSION PREVENTION TEAM) ALERT**	**PROCESS:** **APT NOTIFICATIONS – SWITCHBOARD**
REVIEW DATE: 3/28/2020	**DOCUMENT OWNER: MARILYN RILEY**

Step	Description	Key Point / Image / Reason	Who	Time
1	Switchboard receives call to 6-3630 from unit staff to activate APT alert.	Unit, room number, behavior observed given to switchboard operator.	Unit staff to switchboard	1 min
2	Overhead Announcement made stating: "APT to unit, (ex. ED) and unit location (ex. room). State overhead announcement three times.	Overall response time of all team members to unit is 10 minutes.	APT Team	10 min
3	Notifies security via radio or phone of APT alert, specifically giving behaviour observed to security team	Switchboard relays APT information to prepare security coming on site	Switchboard	1 min
4	Between the hours of **8:00-5:00**, notifies Unit Manager when he/she is in house.	Refer to switchboard reference for Manager contact information to notify if APT.	Switchboard	1min
5	Between the hours of **8:00-5:00**, notifies CNO when she is in house.	Refer to switchboard reference for CNO contact information to notify if APT.	Switchboard	1min
6	Notify Marilyn Riley on every alert.	Call/text to cell phone @756-427-0939	Switchboard	1 min
7	Notify Chaplain when in house.	Refer to chaplain schedule.	Switchboard	1 min

Appendix K- APT Debrief Tool

Patient Label

Aggression Prevention Team Debriefing

Date: _____ Time: _____
Unit: _____ Room: _____

Responders	Who called the APT: _____ Primary RN Caring for the Patient: _____ Nursing Supervisor Arrival Time: _____ Security Arrival Time: _____ Unit Manager Arrival Time: _____ Chaplain Arrival Time: _____
Reason for the APT	☐Verbal ☐Physical ☐Confusion ☐Drugs/Intoxication ☐Non-Compliance ☐Other_____ **PRE-HUDDLE** Precipitating Events _____ _____ **POST-HUDDLE** Plan of care moving forward _____ _____
Interventions	☐Medication ☐Restraints ☐AMA ☐Verbal De-escalation ☐Close Observation ☐Care Contract ☐Patient Moved to _____ ☐Other_____
Notification/ Documentation	☐Incident Report ☐Nursing Supervisor APT Documentation in Cerner ☐Care Contract initiated Name of MD Notified _____
Staff Injury/Harm Continued Support	☐Employee Injury (☐Intentional / ☐Not Intentional) ☐Employee Injury Reported to Occupational Health Nurse ☐Medical care Needed ☐EAP Referral ☐Crisis Intervention Response Team Called ☐RISE Team Called ☐Communicated for DASH ☐Other _____

Email completed form to mriley6@iuhealth.org (Marilyn Riley)
Give a copy of completed form to Unit Manager

Opportunities for improvement of this process:

Appendix L- APT Audit Tool

APT Audit Tool

Date	Time	MRN	Unit	MD/ Primary RN	AA	Who called APT	Responders	Results/Debrief Tool competed	Comments

Rev 1-5-12-20/MR

Appendix M- Indiana University IRB Approval Letter

INDIANA UNIVERSITY

OFFICE OF THE VICE PRESIDENT FOR RESEARCH

Office of Research Compliance

NOTICE OF IRB REVIEW NOT REQUIRED

DATE:	April 29, 2020
TO:	Marilyn Riley, Principal Investigator UNIVERSITY LEVEL
FROM:	Human Research Protection Program (HRPP) Office of Research Compliance – Indiana University
RE:	Protocol #: 2003613325 Protocol Type: Not Human Subject Research Protocol Title: Reducing Violence in the Emergency Department, Improving Perception of Safety: An Aggression Prevention Team Approach Funding Source: None

The Indiana University Human Research Protection Program has determined that the above-referenced project does not require IRB review for the following reason:

Relevant HRPP policies and procedures governing Human Subject Research can be found at: https://research.iu.edu/compliance/human-subjects/guidance/index.html.

Submission and Review Information:

Type of Submission:	Initial Protocol Application
Level of Review:	IRB Review not required
Date of Determination:	April 29, 2020

You should retain a copy of this letter and all associated documents for your records. Please refer to the assigned KC Protocol number and exact title in future correspondence with our office. Additional information is available on our website at https://research.iu.edu/compliance/human-subjects/guidance/index.html.

If you have any questions or require further information, please contact the HSO via email at irb@iu.edu or via phone at (317)274-8289.

Appendix N- University of Alabama in Huntsville IRB Approval Letter

THE UNIVERSITY OF
ALABAMA IN HUNTSVILLE

_X_ Expedited (see pg 2)
__ Exempted (see pg 3)
__ Full Review
__ Extension of Approval

Date: 23 May 2020

PI: Marilyn Riley
PI Department: College of Nursing
The University of Alabama in Huntsville

Dear Marilyn,

The UAH Institutional Review Board of Human Subjects Committee has reviewed your proposal titled: *Reducing Violence in the Emergency Department, Improving Perception of Safety: An Aggression Prevention Team Approach* and found it meets the necessary criteria for approval. Your proposal seems to be in compliance with these institutions Federal Wide Assurance (FWA) 00019998 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).
Please note that this approval is good for one year from the date on this letter. If data collection continues past this period, you are responsible for processing a renewal application a minimum of 60 days prior to the expiration date.

No changes are to be made to the approved protocol without prior review and approval from the UAH IRB. All changes (e.g. a change in procedure, number of subjects, personnel, study locations, new recruitment materials, study instruments, etc) must be prospectively reviewed and approved by the IRB before they are implemented. You should report any unanticipated problems involving risks to the participants or others to the IRB Chair.

If you have any questions regarding the IRB's decision, please contact me.

Sincerely,

Ann L. Bianchi
IRB Chair
Associate Professor, College of Nursing

OFFICE OF THE VICE PRESIDENT FOR RESEARCH
Von Braun Research Hall M-17 Huntsville, AL 35899 T 256.824.6100 F 256.824.6783

Expedited: form 2

☐ Clinical studies of drugs and medical devices only when condition (a) or (b) is met. (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review. (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

☐ Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

☐ Prospective collection of biological specimens for research purposes by noninvasive means. Examples: (a) hair and nail clippings in a nondisfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

☐ Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).

☐ Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

☐ Collection of data from voice, video, digital, or image recordings made for research purposes.

X☐ Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Exempt form 3:

☐ Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (a) research on regular and special education instructional strategies, or (b) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interviews, or observation of public behavior [1] in which information is obtained in a manner that human subjects cannot be identified directly or through identifiers linked to the subjects and any disclosure of the human subject's responses outside the research would NOT place the subjects at risk of criminal or civil liability or be damaging to the subject's financial standing, employability, or reputation. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement) survey procedures, interview procedures, or observation of public behavior if (a) the human subjects are elected or appointed public officials or candidates for public office, or (b) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs;(iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs. The protocol will be conducted pursuant to specific federal statutory authority; has no statutory requirement for IRB review; does not involve significant physical invasions or intrusions upon the privacy interests of the participant; has authorization or concurrent by the funding agency and does not involve prisoners as participants.

☐ Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture. The research does not involve prisoners as participants.

[1] Surveys, interviews, or observation of public behavior involving children cannot be exempt.

Appendix O- Instruments used- American Hospital Association, *Workplace Violence Staff Assessment Survey*

Workplace Violence Staff Assessment Survey

- **What are the most and/or least effective methods of controlling violence in the ED?**

  Most effective:

- **What improvements could be made to how "high risk" patients (e.g., as suicidal, violent, or altered mental status patients) are handled?**

- **Rate how safe you feel from workplace violence in the ED overall as well as in each area of this ED.**

	Not at all Safe									Extremely Safe
Overall level of safety in the ED	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Triage	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Exam (e.g. non-critical area)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Crash (e.g. critical care/trauma area)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Pediatric	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Psychiatric holding	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Quick care (e.g. fast track)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

- **How long ago did you receive training on preventing and/or mitigating ED workplace violence?**

  Never ..... ①
  0-3 months ..... ②
  4-6 months ..... ③

7-9 months ..... ④
10-12 months ..... ⑤
More than 12 months ⑥

- **If you have experienced workplace violence while working at this facility, did you formally report the occurrence(s)?**

  No, I did not formally report the occurrence(s) ..... ①
  Yes, I formally reported some of the occurences..... ②
  Yes, I formally reported any occurrence of workplace violence ③

- **Have you been instructed to report physical or verbal abuse regardless of the level of severity or harm?**

  No..... ①
  Yes..... ②

- **How do you report workplace violence?**

-

-

- **From the actions listed below, indicate which of the following items you believe to constitute workplace violence. Additionally, indicate whether you have personally experienced any of the items.**

	I consider this action to be workplace violence		I have personally experienced this action while at work in this ED	
	Yes	No	Yes	No
Bitten	①	②	①	②
Called names	①	②	①	②
Hair pulled	①	②	①	②
Harassed with sexual language/innuendo	①	②	①	②
Hit (e.g., punched, slapped)	①	②	①	②

Workplace Violence Staff Assessment Survey

Hit by thrown objects	①	②	①	②
Kicked	①	②	①	②
Pinched	①	②	①	②
Pushed/shoved	①	②	①	②
Scratched	①	②	①	②
Sexually assaulted	①	②	①	②
Shot/shot at	①	②	①	②
Spit on/at	①	②	①	②
Stabbed	①	②	①	②
Sworn/cursed at	①	②	①	②
Threatened with physical harm	①	②	①	②
Verbally intimidated	①	②	①	②
Voided on/at	①	②	①	②
Yelled/shouted at	①	②	①	②
Other (describe):	①	②	①	②
Other (describe):	①	②	①	②
Other (describe):	①	②	①	②

- **How prepared do you feel to manage aggressive or violent behavior?**

Not at all Prepared									Completely Prepared
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

- **Do you feel that workplace violence from patients and/or visitors is simply a "part of the job" in the ED?**

No..... ①
Yes..... ②

- **Do you feel that workplace violence has increased, remained the same or decreased over the past year?**

Increased..... ①
Remained the same... ②
Decreased..... ③

- **Please rate how effective our hospital's security personnel is in preventing violence against ED staff in our ED.**

Not at all Effective									Extremely Effective
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Workplace Violence Staff Assessment Survey

- **Please rate how adequate the amount of time security is provided in our ED is in preventing violence against ED staff:**

Not at all Adequate									Completely Adequate
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

- **What types of violent situations do you feel most and/or least prepared to handle?**

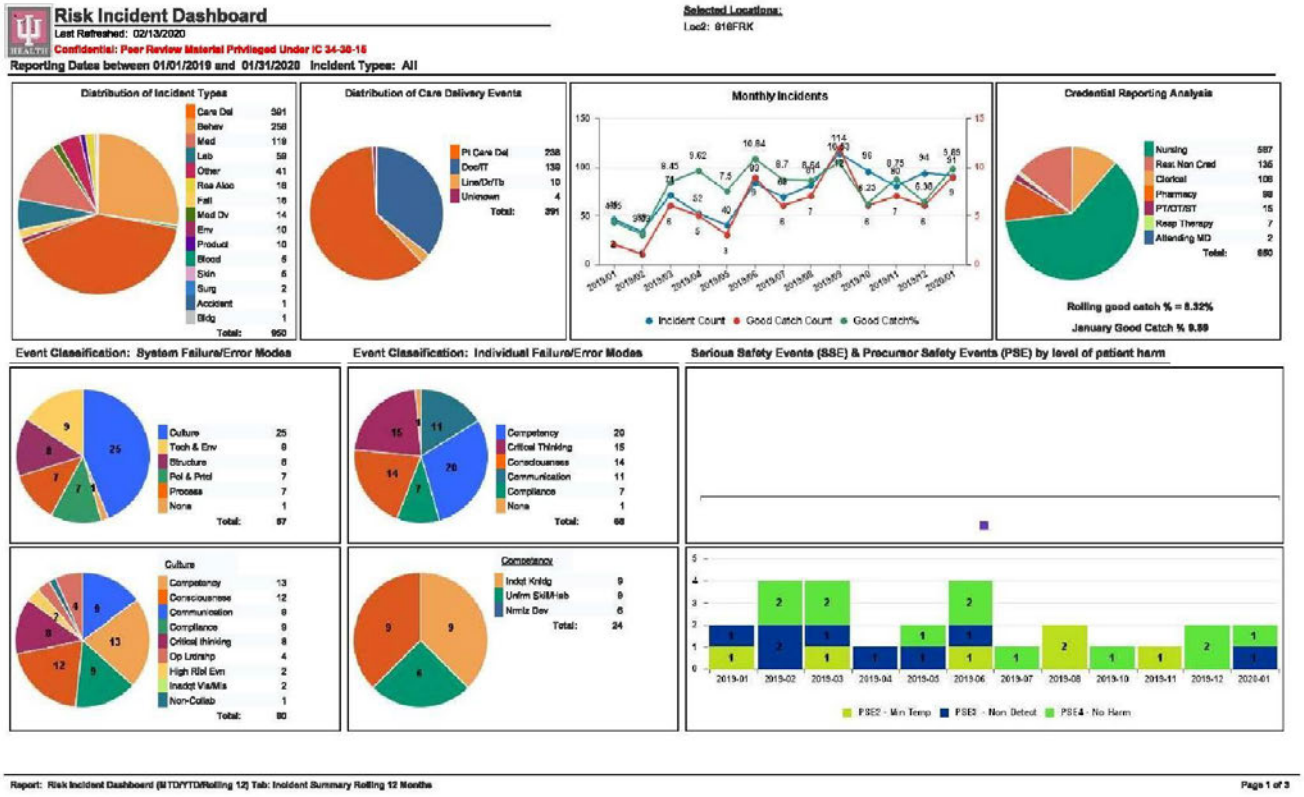
Most prepared:

- **What other suggestions do you have for improving how workplace violence is handled in this emergency department (before, during, and after incidents occur)?**

Appendix P- Demographic and additional questions added to survey

1. How many years have you been a Registered Nurse?
2. How many years have you worked at IU Health?
3. What is your age?
    a. 18-25
    b. 26-35
    c. 36-45
    d. 46-55
    e. 56-65
    f. Over 65
    g. Prefer not to answer
4. What is your gender?
    a. Male
    b. Female
    c. Prefer not to answer
5. What shift do you work?
    a. Days
    b. Nights
    c. Weekends
    d. Various
6. Enter a 4-digit PIN
7. Any additional comments
    a. Free text
8. Posttest question added: Did you participate in the APT
    a. Yes/No
9. Do you feel safer with the APT resource?
    a. Yes/No

Appendix Q- Incident reports summary-2019



TABLES AND FIGURES

TABLES AND FIGURES

Table 1- APT Team Member Roles and Definitions

APT Team Member Roles and Definitions

APT Members	Methods to identify patients for APT	Methods to activate the APT	Methods to communicate	Methods to incorporate APT into the care process	Methods to measure the effectiveness
• RN • Nursing Supervisor • Security • Facilities • Chaplain Nurse Manager	Response criteria: • Acutely agitated patient: yelling, threatening, demanding, cursing, responding to hallucination or delusions • Patient in distress and at risk for danger to self, others • Confused patient threatening to leave Against Medical Advice (AMA) Patient experiencing drug/alcohol withdrawal symptoms and exhibiting acting out behaviors.	• Dial 6-3008 to the switchboard to make overhead page "Need APT to room XX"	• The Nursing Supervisor will assess the patient and facilitate stabilization of patient's behavior • Security and the Nursing Supervisor will coordinate with the RN to modify the plan of care • Nursing Supervisor or RN will make a clinical note in the EMR • Nursing Supervisor or RN will flag the chart to indicate aggressive behavior event Nursing supervisor will conduct debrief with team and place copy of form in the CNO mailbox	• Awareness of APT among MDs through Medical Executive Committee, staff briefs, etc. • Awareness of APT among nurses through staff meetings, unit meetings, Health and Safety Taskforce meetings, Professional Practice Council meetings, and Nursing Leadership team. Daily rounding to all areas in the hospital to connect with disciplines outside of nursing	• Positive feedback from physicians and staff • Weekly trending of data: Incident reports, security reports, number of APT calls • Spot check audits to ensure fidelity of team • Weekly review of debrief forms Weekly EMR audits

Table 2- Question #10 data

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
					95% Confidence Interval of the Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper			
Pair 1	Pretest - posttest	-4.222	3.346	1.115	-6.794	-1.650	-3.786	8	005

Table 3- Question #11 data

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	Pretest - Posttest	-4.667	9.695	3.232	-12.119	2.786	-1.444	8	.187

Table 4-Question #12 data

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	Pretest - Posttest	-5.444	12.063	4.021	-14.717	3.828	-1.354	8	.213

Table 5- Question # 13 data

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper			
Pair 1	Pretest - Posttest	-10.333	8.544	2.848	-16.901	-3.766	-3.628	8	.007

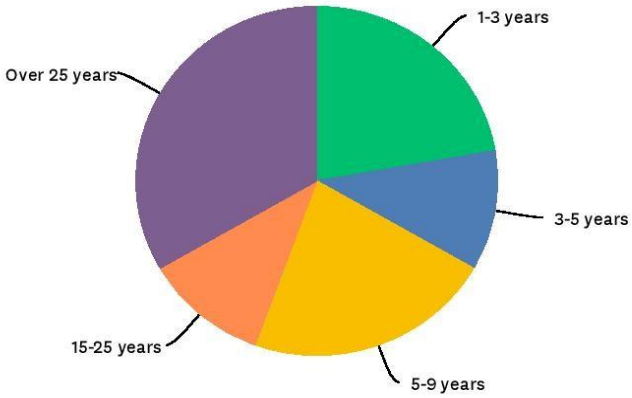
FIGURES

Figure 1- Demographic Data-Pretest Survey-Years as an RN

Workplace Violence Staff Assessment

Q1 How many years have you been a Registered Nurse?

Answered: 9 Skipped: 0



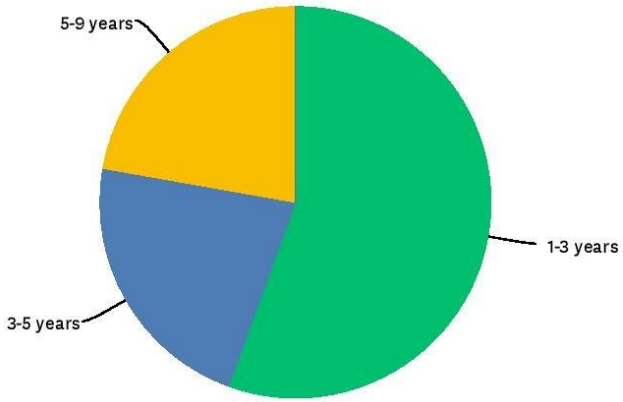
ANSWER CHOICES	RESPONSES	
1-3 years	22.22%	2
3-5 years	11.11%	1
5-9 years	22.22%	2
10-15 years	0.00%	0
15-25 years	11.11%	1
Over 25 years	33.33%	3
TOTAL		9

Figure 2- Demographics-Tenure at IU Health

Workplace Violence Staff Assessment

Q2 How many years have you worked at IU Health?

Answered: 9 Skipped: 0



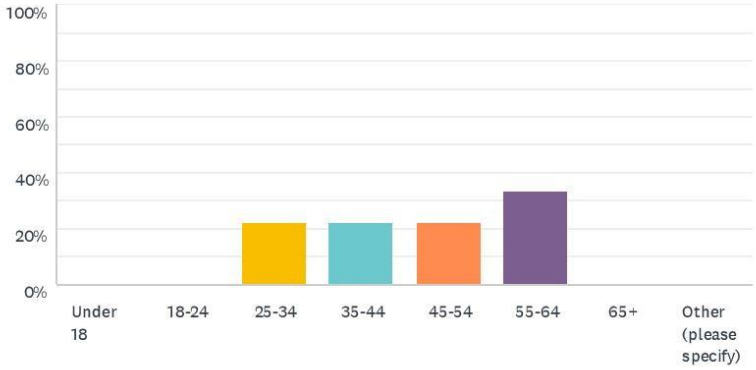
ANSWER CHOICES	RESPONSES	
1-3 years	55.56%	5
3-5 years	22.22%	2
5-9 years	22.22%	2
10-15 years	0.00%	0
15-25 years	0.00%	0
Over 25 years	0.00%	0
TOTAL		9

Figure 3- Demographics-Age

Workplace Violence Staff Assessment

Q3 What is your age?

Answered: 9 Skipped: 0



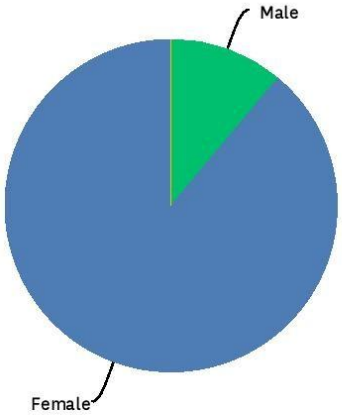
ANSWER CHOICES	RESPONSES	
Under 18	0.00%	0
18-24	0.00%	0
25-34	22.22%	2
35-44	22.22%	2
45-54	22.22%	2
55-64	33.33%	3
65+	0.00%	0
Other (please specify)	0.00%	0
TOTAL		9

Figure 4- Demographics-Gender

Workplace Violence Staff Assessment

Q4 What is your gender?

Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
Male	11.11%	1
Female	88.89%	8
Prefer not to answer	0.00%	0
TOTAL		9

Figure 5- Survey Results-Definition of WPV

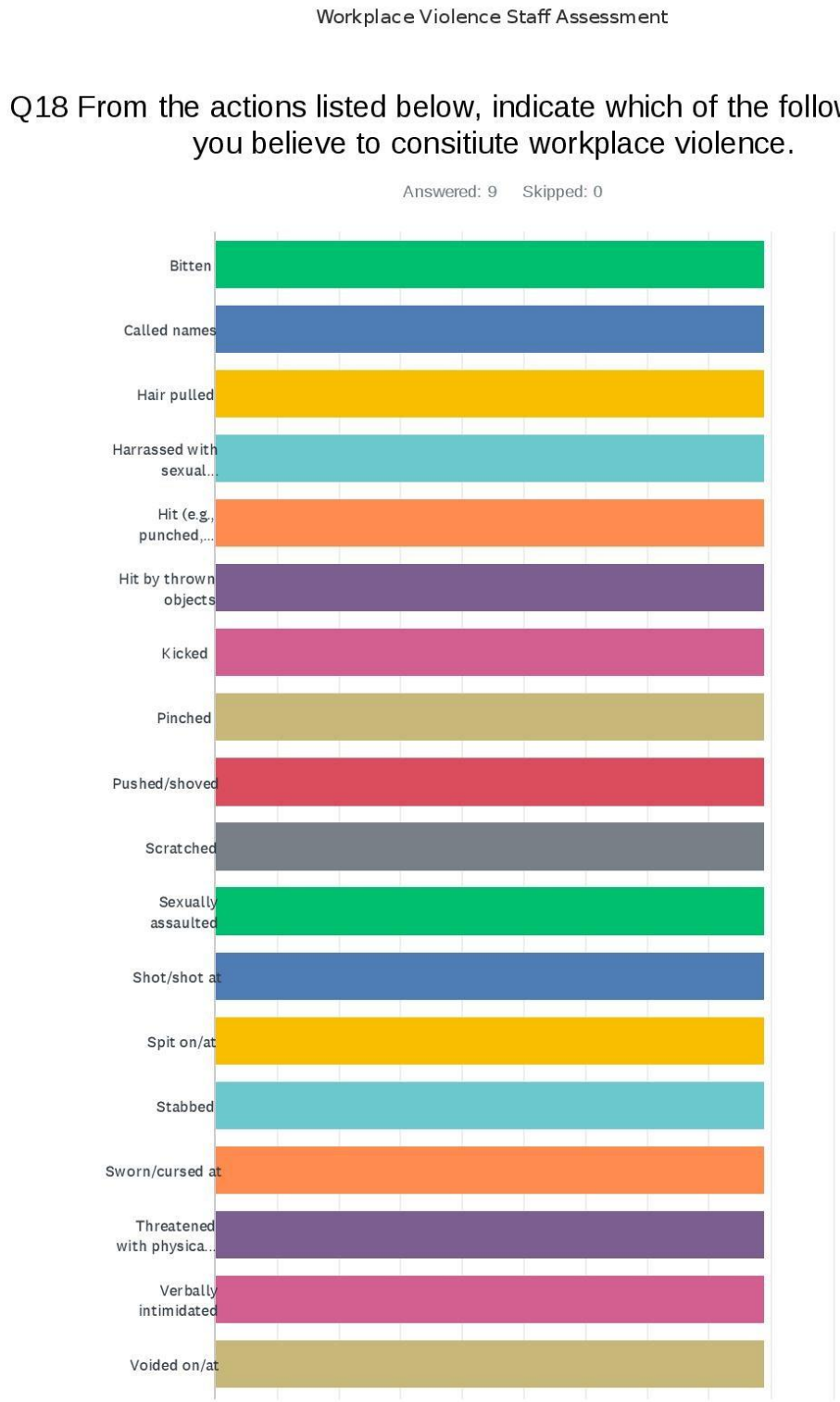


Figure 6- Survey Results- Types of Violence Experienced

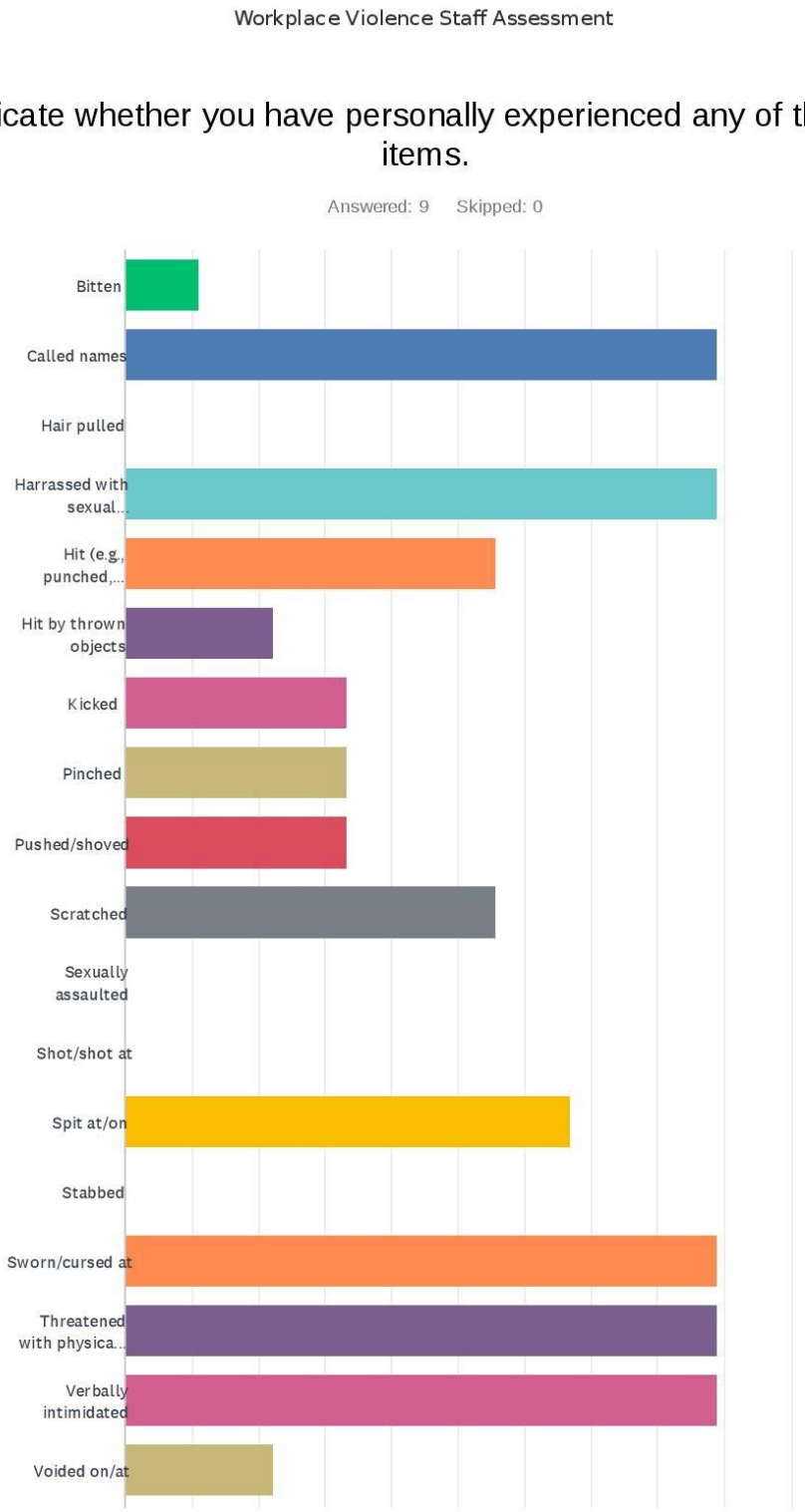
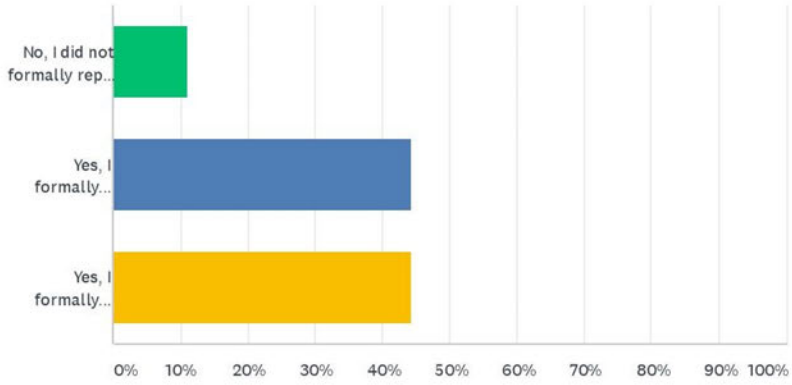


Figure 7- Posttest Survey Results- Reporting WPV

Workplace Violence Staff Assessment Follow up survey

Q15 If you have experienced workplace violence while working at this facility, did you formally report the occurence (s)?

Answered: 9 Skipped: 0



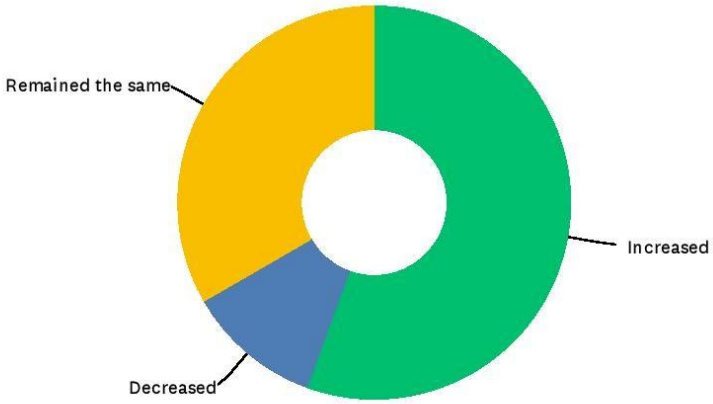
ANSWER CHOICES	RESPONSES	
No, I did not formally report the occurence(s)	11.11%	1
Yes, I formally reported some of the occurences	44.44%	4
Yes, I formally reported any occurence of workplace violence	44.44%	4
TOTAL		9

Figure 8- Pretest Survey Results- WPV Occurrence

Workplace Violence Staff Assessment

Q22 Do you feel that workplace violence has increased, decreased, or remianed the same over the past year?

Answered: 9 Skipped: 0



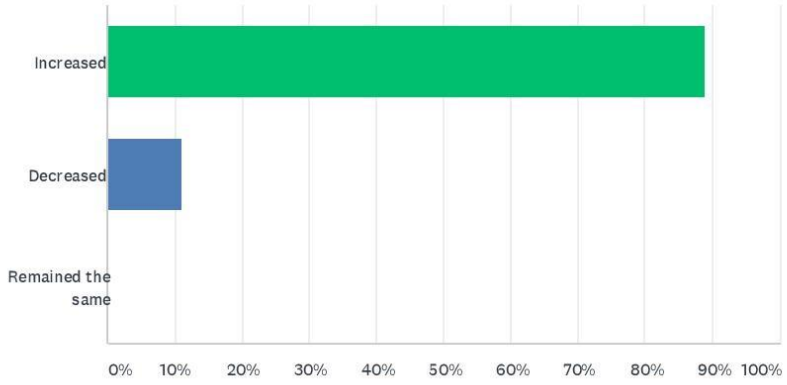
ANSWER CHOICES	RESPONSES	
Increased	55.56%	5
Decreased	11.11%	1
Remained the same	33.33%	3
TOTAL		9

Figure 9- Posttest Survey Results- WPV Occurrence

Workplace Violence Staff Assessment Follow up survey

Q22 Do you feel that workplace violence has increased, decreased, or remianed the same over the past year?

Answered: 9 Skipped: 0



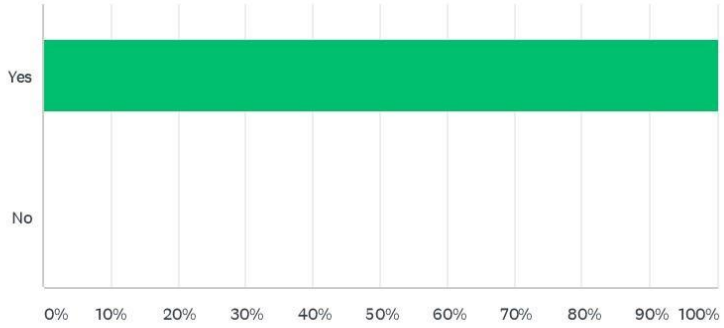
ANSWER CHOICES	RESPONSES	
Increased	88.89%	8
Decreased	11.11%	1
Remained the same	0.00%	0
TOTAL		9

Figure 10-Posttest Survey Results- Participation in the APT

Workplace Violence Staff Assessment Follow up survey

Q24 Have you participated in an APT in the last 3 months?

Answered: 9 Skipped: 0



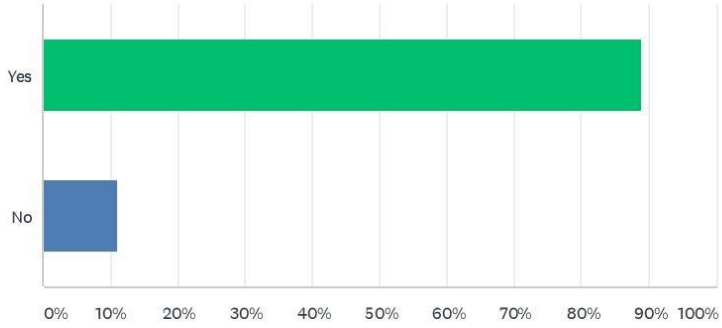
ANSWER CHOICES	RESPONSES	
Yes	100.00%	9
No	0.00%	0
TOTAL		9

Figure 11- Posttest-Survey Results- Perception of Safety

Workplace Violence Staff Assessment Follow up survey

Q25 Do you feel safer knowing you have the APT as a resource?

Answered: 9 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	88.89%	8
No	11.11%	1
TOTAL		9

Figure 12- Weekly Incident Reports

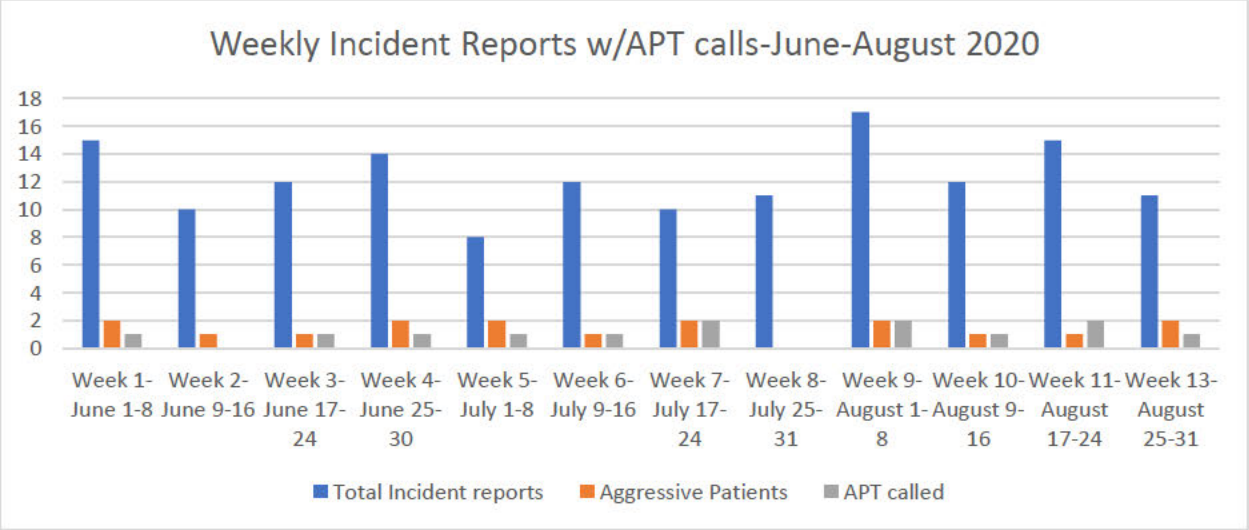
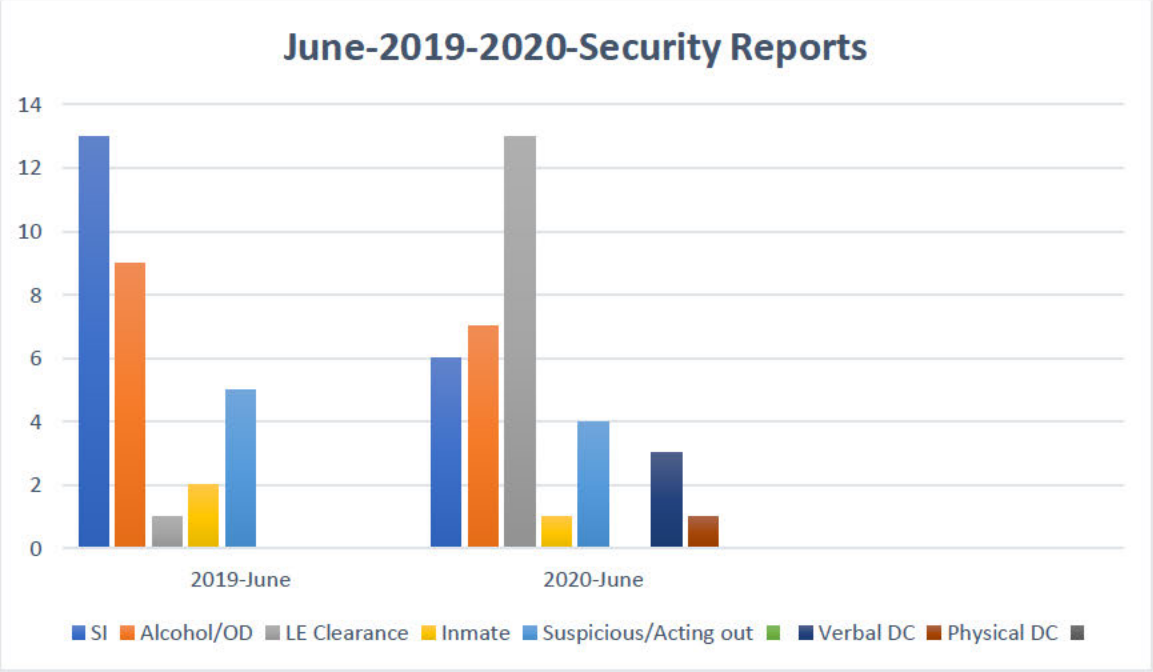
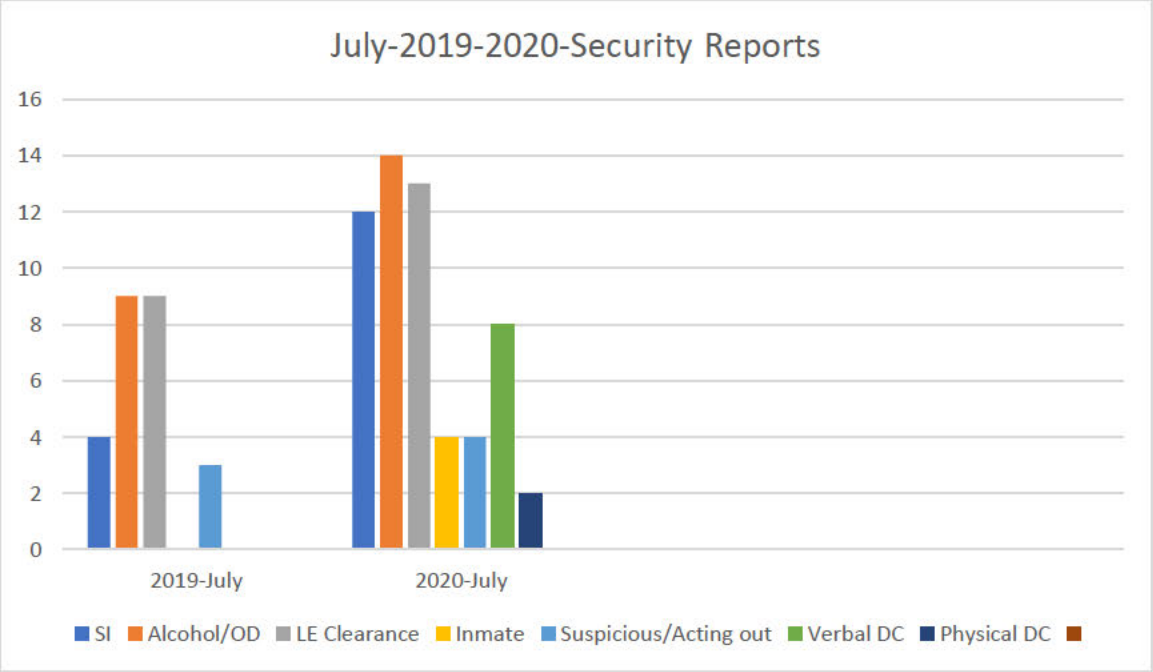


Figure-13- Security Reports-Comparative 2019/2020 for 90-day pilot

June:



July:



August:

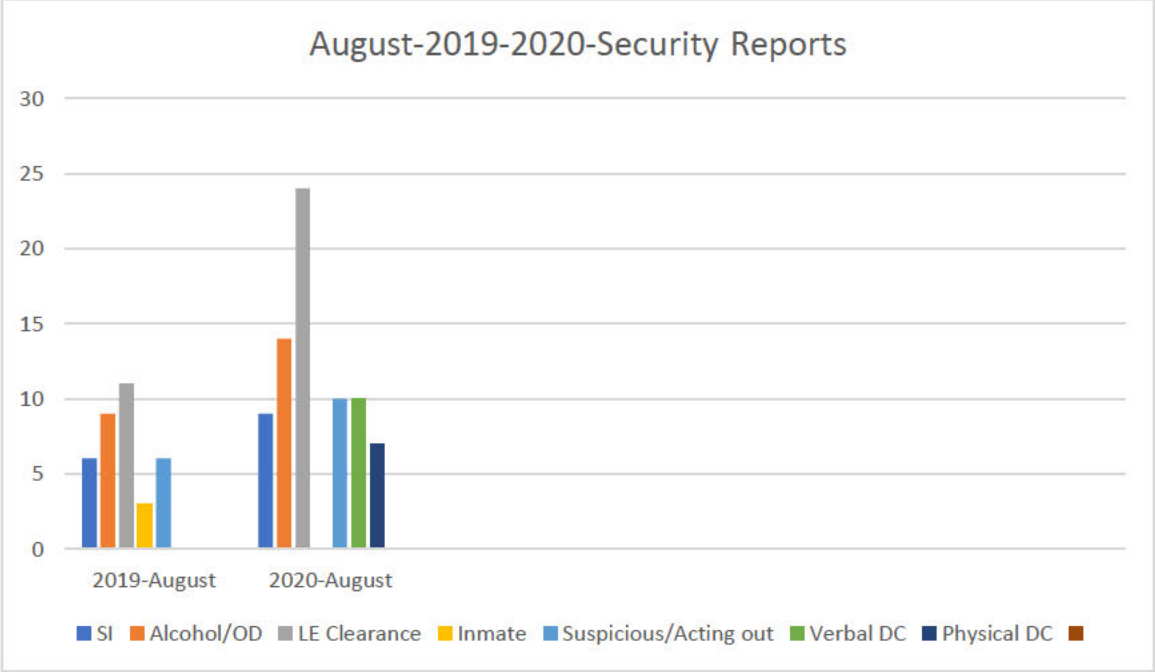

August-2019-2020-Security Reports
30
25
20
15
10
5
0
2019-August
2020-August
SI
Alcohol/OD
LE Clearance
Inmate
Suspicious/Acting out
Verbal DC
Physical DC

Figure 14-Weekly EMR Audit for Flags