Workplace Violence Prevention: Between Patients and Staff Utilizing the Broset Violence Checklist in an Adult Medical Surgical Telemetry Unit

By

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Abstract

Aggression against nurses physically and verbally in the workplace is an invasion of human dignity and jeopardizes the integrity of the individual and the nursing profession. This applied project highlights the importance of bringing awareness to violence against nurses and how nurses experiencing hostility in the workplace ultimately affect patient care. Awareness, education, and workplace violence prevention tools are critical components necessary to counteract workplace violence towards nurses. The Broset Violence Checklist (BVC)—an assessment tool with the main goal of assessing the potential for a patient to become violent within a 24-hour period—is a valuable tool to be added to the toolkit of violence prevention measures to protect nurses and patient care. Additionally, the BVC has been used in various psychiatric and emergency room departments, with comprehensive research studies showing positive outcomes utilizing the tool. Currently, there are no assessment tools used in the in-patient setting for Medical Surgical Telemetry units. Violence does not just occur in the Emergency Department or a Psychiatric Hospital. In-patient nurses are in dire need of a tool to help with early recognition of potential violence to diminish the chances of patients actually becoming violent. The aim of this applied project was to provide an educational module for nurses on using the BVC in the in-patient setting on Medical Surgical Telemetry units.

Keywords: workplace violence, Broset Violence Checklist, Medical Surgical Telemetry units

CHAPTER 1

Introduction

The nursing profession needs a myriad of tools and resources to battle the war on workplace violence. One of the best ways of treating workplace violence is active preventative measures to stop violence prior to violent acts happening to nurses. Among many assessment tools, the Broset Violence Checklist (BVC) is an assessment tool employed for the purpose of anticipating the potential of violence to staff from patients. Various studies have shown positive results implementing the BVC tool. Woods and Almvik (2002) created the BVC that is essentially derived from the original research of Linaker and Busch-Iversen. Linaker and Busch-Iversen's (1995) study included analyzing patients' behaviors at the Broset Forensic Psychiatry facility in Norway, focusing on what their behaviors were in a 24-hour period before a violent episode. Linaker and Busch-Iversen pointed out that six main behaviors were commonly noted before a violent act from a patient, "confusion, irritability, boisterousness, physical threats, verbal threats and attacks on objects" (1995, p. 250). The authors further noted that their research shows that both individuals with mental disorders and no mental disorders exhibit the same "behaviors" (1995, p. 250) before any violent episodes were displayed.

Woods and Almvik (2002) took the six behaviors and developed the BVC tool placing a zero if the patient was not displaying the behavior or one if the patient showed the noted behaviors—scoring each of the six behaviors. Moreover, if the total was zero, the chances of a violent encounter were slim; a score of one or two suggest that there is a "moderate" risk of a violent act occurring. A score of three or higher suggests that the

risk of a violent act is extremely "high," and the need for interventions is imperative (Woods & Almvik, 2002, p. 103).

Almvik, Woods, and Rasmussen (2000) implemented and evaluated the study that took place at four in-patient psychiatric hospitals in Norway with the main objective of testing the effectiveness of the BVC tool. Almvik et al. (2000) point out that the BVC, geared towards the intentions of being a quick resource for nurses as a BVC assessment tool, is meant to be used to assess patients within about five minutes, versus other assessment tools such as the "Dynamic Appraisal of Situational Aggression-Inpatient Version (DASA-IV); Psychopathy Checklist: Screening Version (PCL-SV); Violence Risk Screening-10 (V-RISK-10); Short-Term Assessment of Risk and Treatability (START); Violence Risk Appraisal Guide (VRAG); Historical Clinical Risk Management-20 (HCR-20); McNiel-Binder Violence Screening Checklist (VSC)" (Anderson & Jenson, 2019, p. 114).

This applied project will provide an audio-visual educational offering in Panopto on how to use the BVC assessment tool on a Medical Surgical Telemetry unit. The purpose is to aide nurses with a tool to help predict the potential for violence from patients or visitors of patients.

Background

Nurses attacked in the workplace is not commonly talked about among the general public; however, according to the American Nurses Association (ANA), "13% of missed worked days are due to workplace violence" (ANA, n.d.-3). Statistics of how often a nurse experiences workplace violence while trying to provide compassionate, empathic, high-quality care shows it is a common occurrence in the workplace setting. According to the American Nurses Association

(2021), one out of four nurses has experienced some form of workplace violence. Furthermore, the chances of allied healthcare employees being attacked in the workplace are greater than police officers or prison guards (ANA, 2021).

Nachreiner, Gerberich, Ryan, and McGovern's (2007) "Minnesota nurses' study: Perceptions of violence and the work environment" found that within the U.S. during 1993 to 1999, out of all allied healthcare workers, nurses were among the highest employees to experience workplace violence. The National Institute for Occupational Safety and Health [NIOSH] (2020) categorizes workplace violence into four types: "type 1 criminal intent, type 2 customer/client, type 3 worker on worker, type 4 personal relationship." The NIOSH (2020) identifies "type 2 customer/client" as the most prevalent form of workplace violence that nurses experience. The ANA (n.d.-3) defines workplace violence as "any form of physical violence, sexual in nature, verbal threats, and psychological aggressions; any act or threat of physical violence, harassment, intimidation or other threatening, disruptive behavior from patients, patient's family members, external individuals, and hospital personnel" (ANA., n.d.-3).

Significance of the Study

A significant problem is nurses experiencing workplace violence in the hospital and other healthcare settings (Speroni, Fitch, Dawson et al., 2014). According to the Occupational Safety and Health Administration [OSHA] (2015), the NIOSH describes workplace violence as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty" (OSHA, 2015, #3826, p. 1). Violence in the workplace has the potential to leave lasting psychological effects on the individual (OSHA, 2015). Thus, there is a need to increase workplace violence prevention programs for nurses to help decrease the chances of violent

threats or incivility actions against nurses from patients or visitors of patients—while trying to care for the patient at the bedside (Speroni et al., 2014).

The Occupational Safety and Health Administration (2015) notes that patients are the biggest cause of workplace violence in healthcare. In 2013, 80% of severe violent occurrences were caused by patients (OSHA, 2015). In an American Nurses Association survey in a group of 3,765 nursing students and registered nurses, 21% reported experiencing some form of physical violence done to them while in the workplace (OSHA, 2015).

How does this affect nurse's ability to provide patient-centered high-quality care? Nursing staff experiencing violence at work in the form of verbal or physical harm may lead to medical attention and wage loss due to employees not being able to work due to the violence of patients or visitors of patients. Violence in the workplace can lead to increased stress and increased risks for medication errors, burn out—ultimately affecting patient care (OSHA, 2015).

Nursing staff members in all departments are at risk of violence at work, and although many healthcare systems have a "zero-tolerance" policy for workplace violence, violence in the workplace setting still exists (Wilkes, Mohan, Luck et al., 2010, p. 71). Wilkes and colleagues (2010) point out that although patients are not the only agents of workplace violence, patients and visitors are common primary sources of violence toward nurses. Wilkes et al. (2010) note that there are the obvious effects of physical violence. Some of the psychological effects on the individual are depression, burnout, anxiety, insomnia, and PTSD (Wilkes et al., 2010). Therefore, it is vital to provide nurses

education, resources, and tools to help safeguard themselves from violence and its' longstanding psychological and physical impacts.

Purpose of the Study

The purpose of this applied project is to provide an educational module for nurses on utilizing the BVC on in-patient Medical Surgical Telemetry units. The goal is to provide nurses with a resource on what the BVC assessment tool is and how it can be potentially utilized on in-patient units (see Appendix A-1). Nurses will be able to assess patients, with the hopes of noting concerning behaviors that the patient might be displaying—tally the score and note that if the patient scores higher than a zero (see Appendix A-2), to start implementing a plan for interventions that can be carried out to predict any potential for violent acts or behaviors. The aim is to keep the patient and the nurse safe in the healthcare setting.

CHAPTER 2

Review of the Literature

A literature search was completed to evaluate the history and current research on the Broset Violence Checklist (BVC). The literature review focused on: (1) how the BVC is implemented on the unit within the study, (2) how the staff is educated on the BVC, and (3) what the outcomes are for the tool. A thorough search was conducted, utilizing the search engines PubMed and CINAHL. The search terms used in PubMed were "Broset Violence Checklist" and "BVC," with 35 results. The search terms used in CINAHL were "Broset Violence Checklist" or "BVC," with 44 findings. The search included primary scholarly articles published within the last six years that were in English—systematic reviews and meta-analysis articles were excluded. After the inclusion and exclusion criteria were considered, and duplicate articles were excluded, a total of 15 articles were chosen and examined. During the review process, themes emerged related to this study's topic.

The search of the literature resulted in two quasi-experimental studies (Hvidhjelm, Sestoft, Skovgaard et al., 2016; Sharifi, Shahoei, Nouri et al., 2020), three retrospective studies (Brathovde, 2020; Loi & Marlowe, 2017; Sarver, Radziewicz, Coyne et al. 2019), five prospective studies (Chan & Chow, 2014; Langsrud, Kallestad, Vaaler et al., 2018; Langsrud, Vaaler, Morken et al., 2019; Rechenmacher, Müller, Abderhalden, & Schulc, 2014; Yao, Li, Arthur et al., 2014), one pilot study (Blair, Woolley, Szarek et al., 2017), and four mixed-method studies (Hvidhjelm, Sestoft, Skovgaard., & Bue Bjorner, 2014; Moursel, Çetinkaya Duman, & Almvik, 2019; Partridge & Affleck, 2018; Theruvath-Chalil, Davies, & Dye, 2020).

One of the studies took place in Iran. Three studies took place in the United States, two studies were completed in China, two studies were conducted in Denmark, two studies occurred

in Norway, one study took place in Austria, two studies occurred in the United Kingdom, one study took place in Turkey, and one study was conducted in Australia. Of the 15 studies: two of the studies took place in the Emergency Department (ED), six studies took place in an in-patient Psychiatric Unit in a hospital setting, one study took place at the psychiatric unit at a correctional facility, four studies were conducted in Psychiatric Intensive Care Units (PICU), one unit was completed in a Psychiatric Clinic within a teaching hospital, and one study was done in a Forensic Psychiatric Unit.

How Staff Members Were Educated on the BVC

The first theme that was analyzed in the 15 articles is how the researchers provided education on the BVC. Moursel et al.'s (2019) study highlighted that they provided an education training class for forty-five minutes to the nurses in the psychiatric clinic. Theruvath-Chalil et al. (2020) educated employees on tools from training done by the unit manager of the PICU and authors of the study. Furthermore, their study incorporated these training classes with video dramatizations giving scenarios that might arise; and providing opportunities for staff to practice utilizing the BVC (Theruvath-Chalil et al., 2020).

Sharifi and colleagues' (2020) study conducted a four-hour class that included a PowerPoint presentation and handouts explaining what the BVC is and how to use the checklist. Additionally, one of the investigators for their study would do an hour in-service on how to properly use and assess patients with the BVC tool for the day shift and night shift (Sharifi et al., 2020). In Sarver and colleagues' (2019) study, they administered training through a video that provided examples of nurse-patient interactions and having the RN being trained to perform the BVC on the patient in the video. In Yao et al.'s (2014) study, they provided short 20-minute training workshops in addition to printouts of the BVC tool for all nurses who were involved in

the study. Brathovde (2020) notes that all 24 nurses at the psychiatric 28-bed unit at a teaching hospital were provided a five-minute module from the BVC online site (Almvik, n.d.), and the training primarily focuses on how to assess patients for a potential violent outburst and how to score patients using the BVC. Another study by Hvidhjelm et al. (2016) took a three-month preparatory time to train the staff members prior to beginning their research study data collection at 15 psychiatric units, and seven units received training on how to use the BVC.

Blair and colleagues' (2017) research study involved a decrease in restraint use and secluding patients in a psychiatric unit in a teaching hospital, employing interventions such a "standardized 8h crisis intervention course," "risking connections" "(a two-day program based on a trauma-informed model of care; the goal of which is to reduce staff behaviors that can exacerbate "trauma reactions" in patients)" (Blair et al., 2017, p. 3). In addition, Blair et al.'s (2017) training and measurement of interventions included providing training and using the BVC.

Partridge and Affleck (2018), in their study, educated security officers who carried out the assessment of patients for potential violence in an emergency department with the BVC. The security officers were given training on how to use the BVC and, in addition, were required to take "aggressive behaviour management training that includes occupational violence awareness and de-escalation" (Partridge & Affleck, 2018, p. 34). Chan and Chow (2014) note that the training for their study entailed a total of 65 nursing staff who were trained and participated in the study using the BVC and the Dynamic Appraisal of Situational Aggression (DASA) for evaluation of patients for the potential of violence; in addition to educating them on the SOAS-R to document violent episodes. The hour-in-length training sessions provided to the nursing staff (Chan & Chow, 2014) incorporated video case scenarios on the tools being used to address

concerns or questions. The authors spent a week testing out the tools that would be used in the study. The researchers listed instructions and guidelines for their study at the five units the study was done on and visited the units to ensure adherence with the study aims and proper usage of the tools (Chan & Chow, 2014). Langsrud et al. (2019) pointed out that staff was already aware and educated on the use of the BVC.

How Researchers Implemented the BVC

The second theme that was examined in the 15 articles is how the researchers implemented the BVC. Moursel and colleagues (2019) note that nurses within the psychiatric clinic utilized the BVC to help anticipate violence from a patient and also used the Overt Aggression Scale (OAS). During their study, the nurses in the psychiatric clinic completed the BVC during the day and night shifts to assess for possible violence (Moursel et al., 2019). Theruvath-Chalil et al. (2020) included the BVC as a standard of care, having the nurses during the three shifts in the PICU complete the BVC, and all the scores were tallied and reviewed during the change of shift report. Moreover, Theruvath-Chalil et al. (2020) report that care plans were updated and measures were taken, such as changes to medications, environment, and staff interactions.

Sharifi and colleagues (2020) reported that when a patient was admitted, the nurse completed the BVC for the patient, friend, or family member of the patient and for the potential of a violent act from the patient or the patient's visitors—and included it in the patients' medical records. Furthermore, they used the BVC to assess for potential violence and violent episodes to be recorded using the "staff observation aggression scale-revised (SOAS-R)" (Sharifi et al., 2020, p. 2). Sarver and colleagues (2019) reported that Registered Nurses for an in-patient

psychiatric unit completed the BVC checklist on all patients when admitted to the unit and as a part of routine care.

In Yao and colleagues' (2014) study, they reported that when first implementing the BVC, they had twelve nurses with the most seniority assess patients that were admitted to the psychiatric hospital. After this trial was done, to make sure that the tool was being used correctly and the same way among the nurses, the tool was used twice daily during the day shift and twice during the night shift by the nurses for the first seven days of the patients' stay at the hospital (Yao et al., 2014). In addition, Yao et al. (2014) interviewed nurses for feedback on the BVC tool and checked for any concerns that arose. Brathovde (2020) used the BVC to assess patients the first three days that the patient was admitted to the psychiatric unit.

In Hvidhjelm et al.'s (2016) study, employees used the BVC every shift to assess patients. "Staff members were instructed to act on the BVC score according to standard guidelines (Almvik & Woods, 1998): a sum score of zero (none of the behavior present) suggests that the risk of violence is low; a score of one or two suggests that the risk is moderate and that preventative measures should be taken; and a score of three or higher suggests that the risk of violence is very high, that immediate preventative measures are required, and that plans for managing an attack should be activated" (Almvik et al., 2000; Hvidhjelm et al., 2016, p. 962). Interventions used were noted on the BVC form (Hvidhjelm et al., 2016).

Blair and colleagues (2017) made using the BVC to assess patients as a part of the standard of daily care. It was used by the admitting physician and the nurses every shift daily for the three shifts. The nurses in Rechenmacher et al.'s (2014) study assessed patients utilizing the BVC-CH two times daily for the duration of their study, about six weeks in length. Rechenmacher et al. (2014) reported that "Abderhalden et al. (2004, 2006) translated the BVC

into the German language (Switerland-CH) and extended it with the Visual Analog Scale (Vas), which is completed by psychiatric nurses as a subjective clinical assessment of the short-term risk of violence" (Rechenmacher et al., 2014, p. 203).

In Hvidhjelm and colleagues' (2014) study, training on how to understand and use the BVC was provided to staff members involved in their study, in addition to training on how to use the Staff Observation Aggression Scale-Revised (SOAS-R). Partridge and Affleck (2018) highlights that the security officers who participated in their study assessed patients in the ED waiting to be admitted for care during the triage process: scoring the patient and documenting the score into "report Exec" (p. 32), a database that security officers primarily use to maintain data on violent acts or aggressive encounters.

Chan and Chow (2014) reported that two nursing staff completed the BVC and DASA together at once, the first two weeks a patient was admitted. Langsrud et al. (2019) reported on how the nurses used the BVC to assess patients after observing the patient for about an hour during each shift. In a previous study, Langsrud and colleagues (2018) reported that the nurses observed the patients while asleep and used the BVC tool to assess the patients three times a day while the study took place. Loi and Marlowe (2017) noted in their study that "A specialist in General Adult psychiatry (Felice Loi) was responsible for the retrospective ratings of the participants' clinical entries in the electronic medical records" (p. 2). Furthermore, Loi and Marlowe (2017) incorporated the East London Modified Broset Checklist to assess patients in the PICU, a scale based on the original BVC.

How Effective is the BVC?

The third theme that was evaluated in the 15 articles is how effective the BVC was the researchers implemented. It is evident how workplace violence in healthcare settings poses a

threat to the nursing profession, quality of patient care, and the morale of the nursing staff. Research shows that an assessment tool such as the BVC has excellent potential to be valuable and effective in being proactive in workplace violence prevention modalities. Theruvath-Chalil et al. (2020) discuss in the closing of their study that integrating the use of the BVC tool into everyday nursing care allowed the authors to identify patients who had the potential to express violent actions to nursing staff members. Furthermore, after identifying the patients with a high chance of exhibiting violent behaviors towards staff, actions were taken, and an updated care plan was enacted for the high-risk patients (Theruvath-Chalil et al., 2020). Moursel et al. (2019) deemed the use of the BVC at their psychiatric clinic to be resourceful, valid, and a reliable tool. Moursel et al. (2019) point out that the nurses reported that the BVC is effortless and quick to use on patients—although more research would be needed to see if the BVC would provide a prediction of violence from patients for the hospital admission.

Sharifi and colleagues (2020) point out that a combination of implementing the use of the BVC in the study in the ED and having "preventative protocols in this study significantly reduced the mean score of violence and the number of verbal abuse incidents" (p. 5). Additionally, Sharifi et al. (2020) shows the potential of highlighting the importance of using this tool on patients and their visitors with a high potential for violence while being triaged at the ED and the scores being recorded—so that other allied healthcare professionals caring for the patient are aware of the possibility of violence. Sarver and colleagues (2019) found a correlation between high BVC scores and the urgency for interference to help protect the well-being and safety of nursing staff and patients. Moreover, Sarver et al. (2019) highlight that the BVC is useful in pointing out patients who might have the potential for violent acts. Another essential matter worth mentioning is that for violent patients, one of the goals added to their plan of care is

for patients to communicate how they feel without displaying violent behaviors and the potential to hurt staff.

According to Yao and colleagues (2014), the nurses described using the BVC Chinese version of the tool on two in-patient psychiatric units as advantageous, useful, simple, short in duration, and straightforward, and beneficial for detecting patients at risk for violence. The main limitation that Yao et al. (2014) mentions is that its research and study on implementing the BVC cannot be listed or labeled as a general tool that will work across all specialties.

Brathovde (2020) concluded in their study that carrying out the usage of the BVC and awareness of the patient showing any of the six-item BVC behaviors and applying interventions showed positive effects in lowering the number of patients restrained and "improvement in nurses attitudes regarding the use of violence risk assessment tools, especially for nurses 5 years or less of nursing experience" (p. 7). Hvidhjelm and colleagues (2016) found a lowering effect on violent episodes after incorporating the use of the BVC in the standard of care on seven psychiatric units for patients during their admission. As noted in Blair and colleagues' (2017) study, incorporating ongoing assessments of patient behaviors such as with the tools like the BVC and education for nursing staff on crisis intervention measures showed positive contribution to the reduction of violent encounters. However, Blair et al. (2017) point out the need for further studies to show whether the results can be duplicated in other settings.

Rechenmacher et al. (2014) reported on the BVC-CH version of the tool being used on a psychiatric hospital on in-patient units with adequate data to back the efficacy of the BVC and its ability to be predictive for detecting patient's potential for violence. Rechenmacher et al. (2014) point out that although there is evidence to back that the BVC-CH modified tool is resourceful and beneficial, it is recommended that the BVC be tested out first before being rolled out at

facilities. Hvidhjelm et al. (2014) found that a high BVC score showed a connection to a greater chance of a violent encounter from patients. According to Hvidhjelm et al. (2014), the BVC appeared to be somewhat accurate in providing a tool that informs staff of the potential of violence to nursing staff or other patients in the forensic psychiatric unit in a mental health facility. Hvidhjelm and colleagues (2014) reported that "The risk of violence was predicted with a high degree of accuracy by staff using the BVC. Almost four of the 10 patients with a BVC score of 3 or more would be expected to commit a physical attack during the next 24 h. For patients scoring less than 3 on the BVC, the risk of violence was 0.1%" (p. 541).

A different study by Partridge and Affleck (2018) explains that, in the ED, it showed positive results having security officers use the BVC to assess patients being admitted to the ED. Partridge and Affleck (2018) reported that more than 50% of patients or visitors of patients who "scored high risk on the BVC went on to commit violent/aggressive acts in the ED" (p. 35). Partridge and Affleck (2018) highlight that the BVC has the ability to provide great value and information on patients who might be at risk for violence against staff, and the BVC can provide allied healthcare professionals great value to help diminish violence against staff. Moreover, the researchers point out the importance of informing staff members once they pinpoint a patient who might have a high chance of becoming violent, so staff can intervene to help decrease the chance of aggression towards healthcare members.

Langsrud et al.'s (2019) study looked at incorporating a sleep assessment with the BVC to enhance the precision of the tool. The authors concluded that including how long the patient slept and if the patients' sleep was interrupted improved the BVC's accuracy. Another study by Langsrud et al. (2018) used the BVC when assessing patients for violent or aggressive behaviors with a goal to note if there is a difference in BVC scores for patients who showed aggression

with a small amount of sleep, or sleeping patterns that varied, to note a difference. Langsrud et al. (2018) found it to be a useful instrument to delineate the usefulness of the BVC in various settings for different reasons, with the possibility of foreseeing a patient becoming violent. Loi and Marlowe (2017) utilized the East London Modified Broset (ELMB), which is an eight-item checklist of the original six-item BVC, to focus on how patients being secluded showed higher BVC scores and a higher incidence of violence.

Conversely, Chan and Chow's (2014) study compared the validity of the BVC and the Dynamic Appraisal of Situational Aggression (DASA) in a Chinese forensic correctional psychiatric unit. The authors concluded that though the BVC and the DASA appeared to be reliable and useful at detecting potential patients at risk for violence, the DASA appeared to be more useful at the facility the study took place at. According to Chan and Chow (2014), "The DASA is potentially superior because it contains items that could identify the potential antecedents of aggression, in the particular interactional and modifiable variables that were found to be important in previous studies, and it may be more clinically serviceable. We hypothesized that the DASA is a valid and reliable instrument of the risk of in-patient aggression in the Chinese forensic psychiatric setting" (p. 624).

Summary of the Literature Review

The 15 articles provided detail on the findings that materialized during their studies. Researchers explained how the staff were educated on the BVC, and how the researchers incorporated various approaches to provide education—on how to properly use the tool. First, researchers of the 15 articles focused on education of the BVC, and had staff demonstrate competency and proper usage of the BVC, by being checked off prior to using the BVC on patients. Many of the studies education techniques consisted of audio-visual videos, case studies,

workshops, modules, PowerPoint presentations, and handouts. Second, the researchers showed how they implemented their studies. Additionally, some studies point out that they used modified versions of the BVC; how often the tool was used, and who utilized the assessment tool during studies. Third, researchers discuss how effective the BVC tool was, and how many nurses reported that the tool was an easy and quick assessment tool to utilize on patients and or visitors of patients.

A review of the literature has shown that there are several gaps in research. One gap in the literature is that, out of the 15 articles reviewed from the last six years, only three of the studies were conducted within the United States. This caused the investigator of this applied project to expand the literature search to other countries to show what information and knowledge have been collected on the BVC: how the BVC was implemented at the facilities the study took place, how the staff was educated on the tool, and overall effectiveness of the BVC. This data provides relevance to the BVC tool.

Examining studies that took place in other countries may not provide a clear picture of using the BVC tool in the same country that this applied project is being proposed—as all countries are diverse culturally speaking. Furthermore, some cultures might interpret some behaviors as aggressive or violent in nature—whereas other countries might perceive some behaviors as normal or not violent. More studies in the U.S. are needed on workplace violence, assessment tools, and implementing the BVC into practice.

Most of the studies on the BVC showed the validity, specificity, and high possibility of detecting a potential of a patient being violent is high. Furthermore, many of the studies discussed how the BVC is flexible and adjustable, with the ability to add to the BVC tool or take away from it depending on the needs and the setting the tool is being used in. However, most

studies were found to be done on the following units: emergency department, in-patient psychiatric units, correctional facility psychiatric unit, PICU, and a forensic psychiatric unit—with no studies completed on any Medical Surgical Telemetry units or other in-patient floors. This indicates another research gap.

In summary, many of the studies reviewed in the literature incorporated modifications adding to the BVC tool to cater to the needs of the unit or hospital. The 15 research studies were conducted in many different settings around the world, with many different facilities using various education techniques from videos to workshops, and many of the studies had the nursing staff and/or researchers of the study involved. Most of the studies generalized the usefulness and the ability of the BVC to predict the likelihood for aggressive or violent actions from patients or visitors of patients.

CHAPTER 3

Methods

Violence awareness in the workplace towards nurses, from patients and visitors of patients, and preventative measures is the sole intention of this applied project. The objective of the applied project was to provide an educational module for nurses on utilizing the BVC on Medical Surgical Telemetry units. The educational offering included an audio-visual Panopto presentation about 15 minutes in length. Panopto is an audio-visual program used to capture and broadcast materials to an audience.

Additionally, the educational offering sought to explain: (1) what the BVC tool is, (2) how valuable the tool potentially can be for in-patient Medical Surgical Telemetry units, and (3) how to assess for potential violent episodes from patients and visitors of patients (see Appendix A-1 and A-2). Ultimately, the education module instructed the nurses on how to use the BVC tool to assess their patients for the potential for violent encounters during the patient's hospitalization (see Appendix B). No human subjects were involved in producing this applied project, and no IRB approval was needed for the applied project.

Setting

The setting for the education module is meant for an Adult Medical Surgical Telemetry Unit Nurse to be provided background information and instructions on the use of the BVC. The educational offering was created to be used for educational purposes at the University of California Davis Medical Center (UCDMC), an academic Level I Trauma Center in the Sacramento Region (UC Davis Medical Center., n.d.). The educational offering is geared for the Adult Medical Surgical Telemetry Registered Nurse.

Project Explanation

An initial meeting was conducted on Friday, July 30, 2020, with Sharon Demeter, RN, MSN, MA, NP, CNM, and Jessica Vetter, RN MSN, CNS, PMPHNP-BC, the two content experts who both head and run various workplace violence prevention programs at UCDMC. The aim of this initial meeting was to get their approval and establish whether there was a need for usage and education on the BVC assessment tool for Medical Surgical Telemetry units; and to obtain buy-in from Ms. Vetter and Ms. Demeter, two key stakeholders at UCDMC. During the initial meeting, Ms. Vetter and Ms. Demeter emphasized a need for an assessment tool for the medical center's in-patient setting and that currently, the BVC is being implemented at UCDMC as a pilot study in the emergency department, but not in any in-patient units. Additionally, Ms. Vetter and Ms. Demeter pointed out that there is a potential for using components of this educational offering to roll out pilot testing on Medical Surgical Telemetry units at UCDMC in the future—using the BVC.

The investigator developed an educational module offering, *"Preventing Workplace Violence: Employing the Broset Violence Checklist in an Adult Medical Surgical Telemetry Unit"* (see Appendix D), that focused on educating Registered Nurses on the BVC tool for an adult Medical Surgical Telemetry unit. There was no tool in use to assess patients for the possibility of a violent act or aggressive behavior for Medical Surgical Telemetry units. Thus, the primary purpose of this applied project was to produce an educational module for nurses on utilizing the BVC on in-patient Medical Surgical Telemetry units.

The educational module included introducing the BVC: its history and how it can be used as a tool for workplace violence prevention in the Medical Surgical Telemetry in-patient setting. The intended outcome was to create an educational module after consulting the two content

experts, Ms. Vetter and Ms. Demeter, for expertise buy-in and feedback. Moreover, literature was thoroughly searched on the BVC tool. The need for an educational module to be developed was confirmed by the two content experts in this project and involved in workplace violence prevention programs at UCDMC—a teaching hospital in Northern California. The following learning objectives were included in the educational offering: Upon completion of the educational module, the learner will be able to:

- Describe the prevalence of workplace violence towards nurses.
- Define the types of workplace violence nurses experience.
- Explore the impact of workplace violence on both nurses and patient care.
- Outline the 6-items of the Broset Violence Checklist.
- Apply the Broset Violence Checklist to a case study.

CHAPTER 4

Results

This educational module offering was created with the intent of instructing the Medical Surgical Telemetry unit nurses with the goal of educating them on the BVC assessment tool and bringing awareness of why assessment tools such as the BVC are imperative to nursing and patient care. The finished educational module (see Appendix D) was submitted to the two experts, Ms. Vetter and Ms. Demeter, on April 23, 2021.

On April 26, 2021, via email, Ms. Vetter and Ms. Demeter provided content expert feedback and noted that it should provide more data on how effective the BVC is; what the BVC accuracy is for anticipating violence; information on if utilizing the BVC has demonstrated a reduction in violence; information on false positives or negatives when rating patients with the tool. The experts also recommended adding whether the tool had any racial prejudice or discrimination in it; more information in general on using the tool specifically at UCDMC; frequency of the BVC use and who should complete it; where the BVC is found in the electronic medical record (EMR) system; what the next step is after the BVC is completed; if the BVC is being used in any other departments at UCDMC currently. Ms. Vetter and Ms. Demeter pointed out the importance of providing nurses with relevant background information on why employing the BVC is beneficial to the nurse and valuable use of their time.

Ms. Vetter and Ms. Demeter also noted that the case study in the module should incorporate the case study and the background information for workplace violence data. Additionally, Ms. Vetter and Ms. Demeter advised the researcher to use the word “patient instead of customer/client,” and increase the size of the BVC photographs included in the module.

The primary purpose of the module is to educate the RNs on what the BVC is, and how to use the BVC on a Medical Surgical Telemetry unit to assess patients or visitors of patients for a potentially violent encounter, verbal or physical. Therefore, a thorough literature review was done to present studies that have used, analyzed, and implemented the BVC. A review of the literature found that the BVC has been chiefly used on psychiatric units and a few studies in the emergency department. Some of the trends that were noted in the literature review focused on: (1) how the study and BVC were implemented, (2) how nurses were educated, and (3) what the feedback and results of the studies were. Ultimately, the detailed content expert information provided by Ms. Vetter and Ms. Demeter helped to enhance the educational module and lead to the development of an improved educational offering (see Appendix D). The education module was about 15 minutes in length, with audio and Qualtrics post-module survey questions that the users will complete after taking the educational module. The following post-module survey questions were included:

- List three main principles you learned from the module.
- List at least two ways that you will change, in your nursing practice at work, from what you have learned in the module.
- What parts of the module helped you learn?
- What could be improved in the module to strengthen your learning?

CHAPTER 5

Discussion and Conclusion

Workplace violence towards nurses, from patients and visitors of patients, is detrimental to the individual nurse, patient care, and the nursing and healthcare profession. What are we doing to protect our nurses from being attacked, physically and verbally? Research shows no single solution or answers to fix the ever-growing issue of violent acts towards nurses while providing care to patients in healthcare settings. Adding valuable tools and resources that nurses can use to help prevent and decrease violence at work is essential. The literature shows positive results using assessment tools to screen patients at a higher risk of exhibiting violent behaviors and is beneficial to apply interventions when the increased risk for violent patients is identified.

The literature review for this project included 15 peer-reviewed articles on the BVC in a variety of settings, ultimately revealing the potential of usefulness, specificity, and validity the BVC has. Currently, the in-patient units at the University of California, Davis Medical Center (UCDMC), specifically the Medical Surgical Telemetry units, do not have a screening tool that is being used on the floors to assist the nurses in assessing their patients for the possibility of violence. The objective of this applied project is to provide an educational offering with valid research currently on the BVC tool, with the recommendation of implementing a pilot test of using the BVC on a Medical-Surgical-Telemetry unit, since the Emergency Department is currently using the tool.

Limitations

According to researchers, the BVC could be used in an array of healthcare environments, as the tool has the ability to be used in different specialties and has shown to help assess patients—and visitors of patients for potential violence. However, there are a few limitations that

are noted in the literature. Many of the studies on workplace violence and the BVC are outside of the U.S. Out of the 15 articles that met the inclusion criteria for this literature search, only three of the studies took place in the U.S. A geographic review of the research include: two studies in China, two studies in Denmark, two studies in Norway, one study in Austria, two studies in the United Kingdom, one study in Turkey, and one study in Australia. The settings for the research studies include: the emergency department, in-patient psychiatric units, a hospital setting, psychiatric unit at a correctional facility, psychiatric intensive care units (PICU), psychiatric clinic within a teaching hospital, and a forensic correctional psychiatric unit. None of the studies were done on any in-patient units such as Intensive Care Units or Medical Surgical Telemetry units, where there is a critical need for a quick assessment tool on in-patient floors. Violence does not just occur in the emergency departments and psychiatric units; unfortunately, it follows the patient. This shows a need for this applied project. A significant limitation of this educational offering (Appendix D) is that it has not been piloted by learners yet.

Next Steps

Based on the need for a short-term assessment tool such as the BVC, which can be quickly used to assess patients for the likelihood of patients becoming violent or aggressive, the next steps would first entail a pilot test of the educational offering module (Appendix D). This should be done with learners to assess their understanding upon completion of the learning module. To introduce the BVC to Medical Surgical Telemetry Nurses on what the BVC tool is, it is important to present the history of the tool, and how to use the tool. Afterward, conduct a longitudinal assessment to evaluate learners further, and a potential for the BVC tool to be added in the EMR as a part of routine nursing assessment documentation.

Moreover, this investigator has been in contact with the two content experts: Sharon Demeter and Jessica Vetter, who serve on heading workplace violence programs at UCDMC. Both Ms. Vetter and Ms. Demeter have shared that the BVC is being used in the emergency department, and there is a current plan to pilot test the BVC on Medical Surgical Telemetry units to evaluate if using the BVC will help predict potential violent behaviors from patients and visitors—in the in-patient setting.

Conclusions

The increase in violence towards nurses from patients is an indication that a proactive approach is required when trying to create workplace violence prevention tools. Waiting until a violent incident happens to provide interventions is not the path that can be taken any longer. The literature shows several studies on the success of using the BVC in diverse clinical settings in healthcare. A major limitation and a gap in the literature is a lack of studies that use the BVC in in-patient Medical Surgical Telemetry units. This does not mean that the short assessment tool cannot be used on in-patient Medical Surgical Telemetry units; it just has not been pilot-tested yet.

The next step of this applied project is for the educational module (Appendix D) to be pilot tested to ultimately examine the success of utilizing the BVC in the in-patient setting on a Medical Surgical Telemetry unit. This applied project aims to serve as a valuable resource for educating nurses on the BVC tool and how to use the tool before implementing it into routine healthcare practice.

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Appendix A-1: Broset Violence Checklist

•bvc

The Brøset Violence Checklist (BVC©) - quick instructions:
Score the patient at agreed time on every shift. Absence of behaviour gives a score of 0. Presence of behaviour gives a score of 1. Maximum score (SUM) is 6. If behaviour is normal for a well known client, only an increase in behaviour scores 1, e.g. if a well know client normally is confused (has been so for a long time) this will give a score of 0. If an **increase** in confusion is observed this gives a score of 1.

Patient/Client data

Monday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Tuesday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Wednesday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

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

Friday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Saturday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Attacking objects			
SUM			

Sunday / /	Day	Evening	Night
Confused			
Irritable			
Boisterous			
Verbal threats			
Physical threats			
Atacking objects			
SUM			

Almvik, R. & Woods, P. (n.d.) Brøset Violence Checklist (BVC). http://www.riskassessment.no/

Appendix A-2: Interpretation of Scoring

•bvc

The Brøset Violence Checklist

Interpretation and Operationalisation

Interpretation of scoring:

Score = 0 The risk of violence is small

Score = 1-2 The risk of violence is moderate. Preventive measures should be taken.

Score > 2 The risk of violence is very high. Preventive measures should be taken
In addition, a plans should be developed to manage the potential violence.

Operationalisation of behaviours/items:

Confused	Appears obviously confused and disorientated. May be unaware of time, place or person.
Irritable	Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous	Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.
Physically threatening	Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another persons clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Verbally threatening	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking objects	An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.

NB: For the behaviours/items physically threatening, verbally threatening and attacking objects the operationalisation was adapted from the Behavioural Status Index (Reed, Woods & Robinson, 2000) by one of the authors (Woods).

Almvik, R. & Woods, P. (n.d.) Brøset Violence Checklist (BVC). http://www.riskassessment.no/

Appendix B: Educational Module Outline Draft

The aim of this educational module is to introduce the Broset Violence Checklist (BVC) for the Adult Medical Surgical Telemetry Nurse. This educational module will provide a focus on workplace violence preventative measures, the history of the BVC tool, and how to use the BVC tool at the bedside.

Objectives
Upon completion of this online module, the learner will be able to:

- Describe the prevalence of workplace violence towards nurses.
- Define the types of workplace violence nurses experience.
- Explore the impact of workplace violence on both nurses and patient care.
- Outline the 6-items of the Broset Violence Checklist.
- Apply the Broset Violence Checklist to a case study.

Goal: 10-15 minutes in length, voice-over integrated educational module

Introduction
- Introduction Scenario
- Learning Objectives
- Workplace violence statistics
- Workplace violence definitions
- How does workplace violence impact the nurse and patient care?

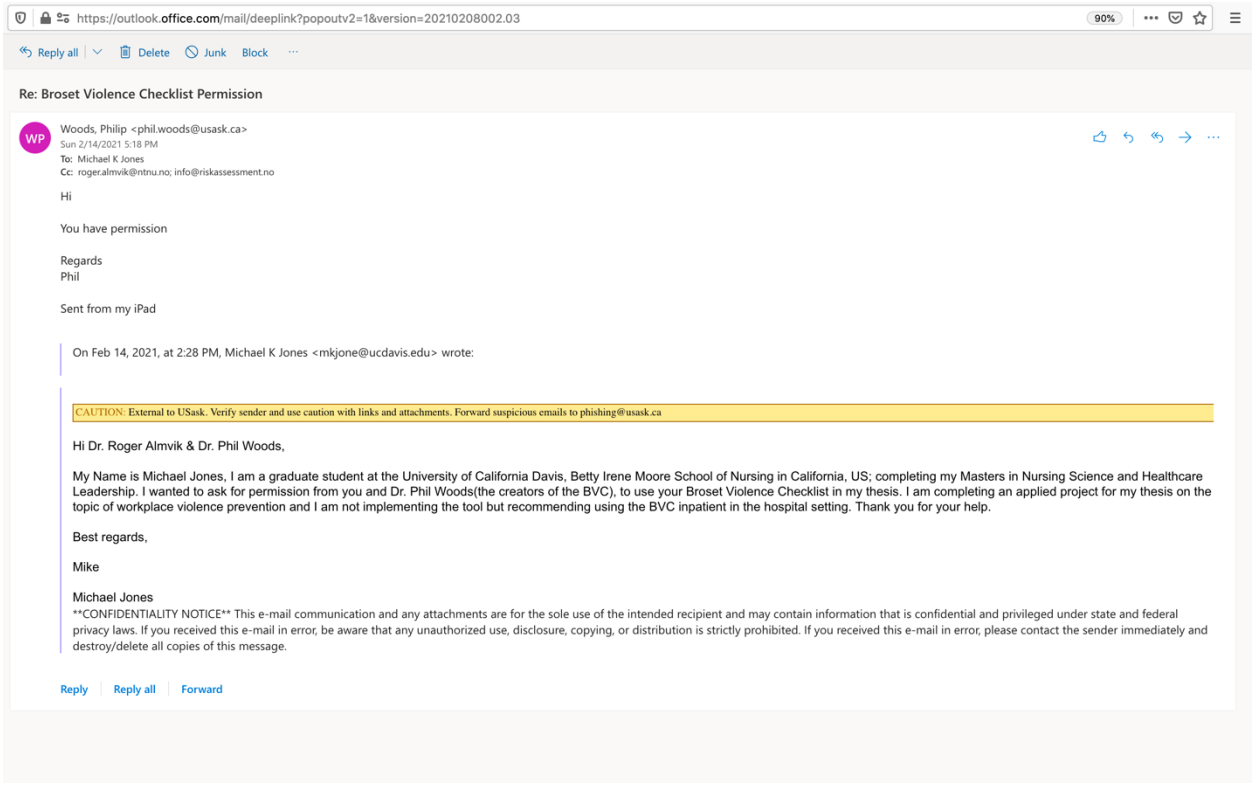
Broset Violence Checklist
- History of the BVC tool
- Explain what the BVC tool is
- Explain BVC terms
- How to Use the Tool?

Case Study

Conclusion
- Summary/takeaway points

Post Module Qualtrics Survey Questions
- List three main principles you learned from the module.
- List at least two ways that you will change, in your nursing practice at work, from what you have learned in the module.
- What parts of the module helped you learn?
- What could be improved in the module to strengthen your learning?

Appendix C: Permission From BVC Creators



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90%

Reply all | Delete | Junk | Block | ...

Re: Broset Violence Checklist Permission

WP

Woods, Philip <phil.woods@usask.ca>
Sun 2/14/2021 5:18 PM
To: Michael K Jones
Cc: roger.almvik@ntnu.no; info@riskassessment.no

Hi

You have permission

Regards
Phil

Sent from my iPad

> On Feb 14, 2021, at 2:28 PM, Michael K Jones <mkjone@ucdavis.edu> wrote:
>
> CAUTION: External to USask. Verify sender and use caution with links and attachments. Forward suspicious emails to phishing@usask.ca
>
> Hi Dr. Roger Almvik & Dr. Phil Woods,
>
> My Name is Michael Jones, I am a graduate student at the University of California Davis, Betty Irene Moore School of Nursing in California, US; completing my Masters in Nursing Science and Healthcare Leadership. I wanted to ask for permission from you and Dr. Phil Woods(the creators of the BVC), to use your Broset Violence Checklist in my thesis. I am completing an applied project for my thesis on the topic of workplace violence prevention and I am not implementing the tool but recommending using the BVC inpatient in the hospital setting. Thank you for your help.
>
> Best regards,
>
> Mike
>
> Michael Jones
> **CONFIDENTIALITY NOTICE** This e-mail communication and any attachments are for the sole use of the intended recipient and may contain information that is confidential and privileged under state and federal privacy laws. If you received this e-mail in error, be aware that any unauthorized use, disclosure, copying, or distribution is strictly prohibited. If you received this e-mail in error, please contact the sender immediately and destroy/delete all copies of this message.

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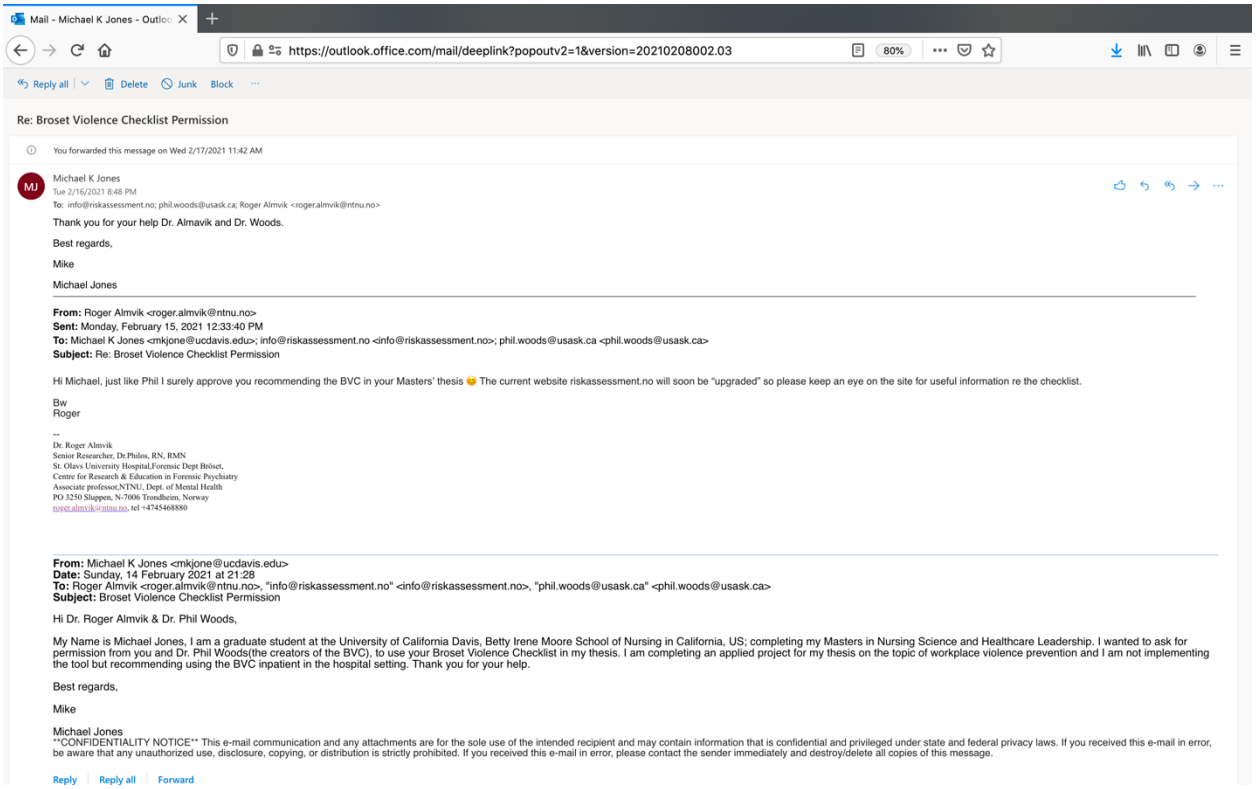
Appendix C: Permission From BVC Creators



Mail - Michael K Jones - Outlook

https://outlook.office.com/mail/deeplink?popoutv2=1&version=20210208002.03

Reply all | Delete | Junk | Block

Re: Broset Violence Checklist Permission

You forwarded this message on Wed 2/17/2021 11:42 AM

MJ Michael K Jones
Tue 2/16/2021 8:48 PM
To: info@riskassessment.no; phil.woods@usask.ca; Roger Almvik <roger.almvik@ntnu.no>

Thank you for your help Dr. Almavik and Dr. Woods.

Best regards,

Mike

Michael Jones

From: Roger Almvik <roger.almvik@ntnu.no>
Sent: Monday, February 15, 2021 12:33:40 PM
To: Michael K Jones <mkjone@ucdavis.edu>; info@riskassessment.no <info@riskassessment.no>; phil.woods@usask.ca <phil.woods@usask.ca>
Subject: Re: Broset Violence Checklist Permission

Hi Michael, just like Phil I surely approve you recommending the BVC in your Masters' thesis The current website riskassessment.no will soon be "upgraded" so please keep an eye on the site for useful information re the checklist.

Bw
Roger

--
Dr. Roger Almvik
Senior Researcher, Dr.Philos, RN, RMN
St. Olavs University Hospital,Forensic Dept Brøset,
Centre for Research & Education in Forensic Psychiatry
Associate professor,NTNU, Dept. of Mental Health
PO 3250 Sluppen, N-7006 Trondheim, Norway
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From: Michael K Jones <mkjone@ucdavis.edu>
Date: Sunday, 14 February 2021 at 21:28
To: Roger Almvik <roger.almvik@ntnu.no>, "info@riskassessment.no" <info@riskassessment.no>, "phil.woods@usask.ca" <phil.woods@usask.ca>
Subject: Broset Violence Checklist Permission

Hi Dr. Roger Almvik & Dr. Phil Woods,

My Name is Michael Jones, I am a graduate student at the University of California Davis, Betty Irene Moore School of Nursing in California, US; completing my Masters in Nursing Science and Healthcare Leadership. I wanted to ask for permission from you and Dr. Phil Woods(the creators of the BVC), to use your Broset Violence Checklist in my thesis. I am completing an applied project for my thesis on the topic of workplace violence prevention and I am not implementing the tool but recommending using the BVC inpatient in the hospital setting. Thank you for your help.

Best regards,

Mike

Michael Jones
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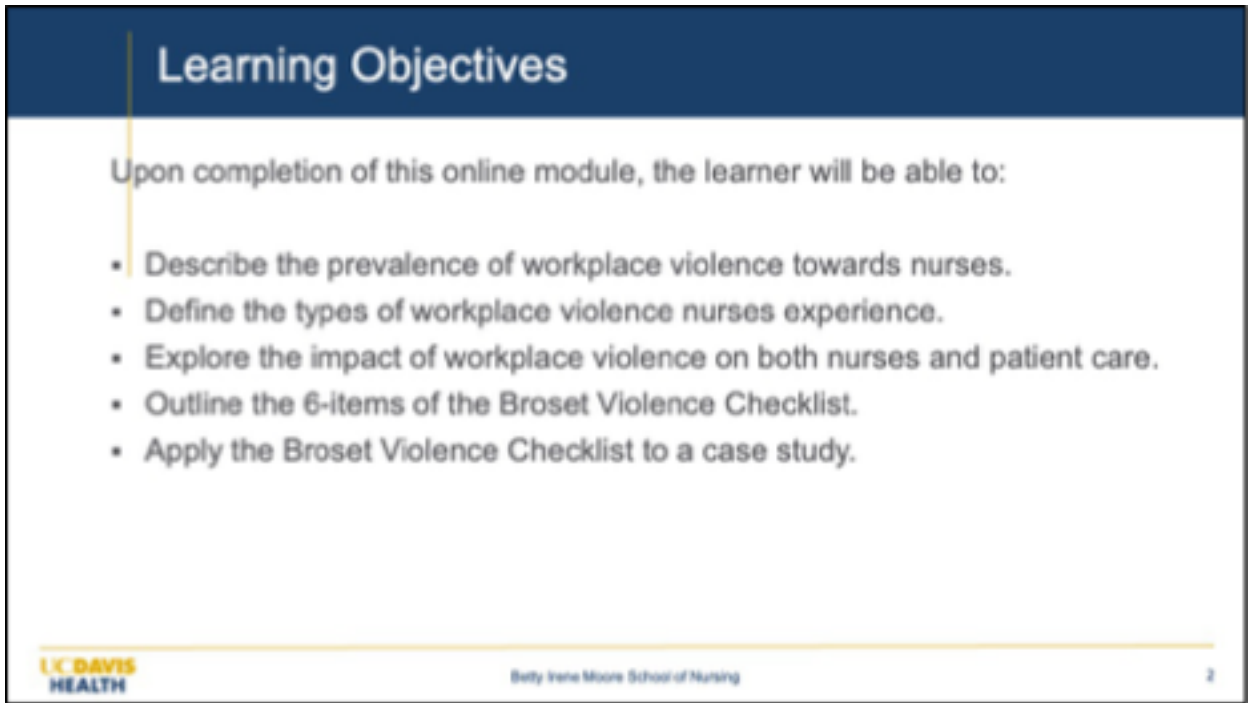
Appendix D: Educational Module Presentation

"You clock into work, on your day shift position on your Telemetry unit and get reports for three of the four of your assigned patients. You are waiting for the night shift nurse to give you a report for Ms. Smith in Room 2. During the reporting, the night shift nurse tells you: (1) why Ms. Smith is in the hospital, (2) about Ms. Smith's past medical history, and (3) what the overall plan is. As you both walk back to the nurses station right before the night shift nurse leaves, the nurse randomly says to you, "Be careful, Ms. Smith can be labile; she got upset with me in the middle of the night, when I had to reapply her Tele leads. She started yelling at me and got close to me in my face in a threatening way saying that she had been asking for a soda during the day and she never got it. You think, 'Okay, I will round frequently on Ms. Smith. Answer any questions she might have and ask her what the goal is for the day and pay attention to any signs that Ms. Smith might be upset.' You have made it about halfway through your shift and so far the day has gone well. It is 12 pm, lunch trays have just arrived by the dietary aide. You have a Renvela medication to give Ms. Smith with her meal. You walk into the room with the Renvela to administer and explain you have the medication to give her. Before you can finish speaking, Ms. Smith shouts "I just want to eat in peace" and throws the plate from the lunch tray towards you and it hits you."

According to the U.S. Bureau of Labor Statistics, in 2018, about 73% of workplace violence was done to allied healthcare professionals in the healthcare setting (U.S. Bureau of Labor Statistics, 2020, April).

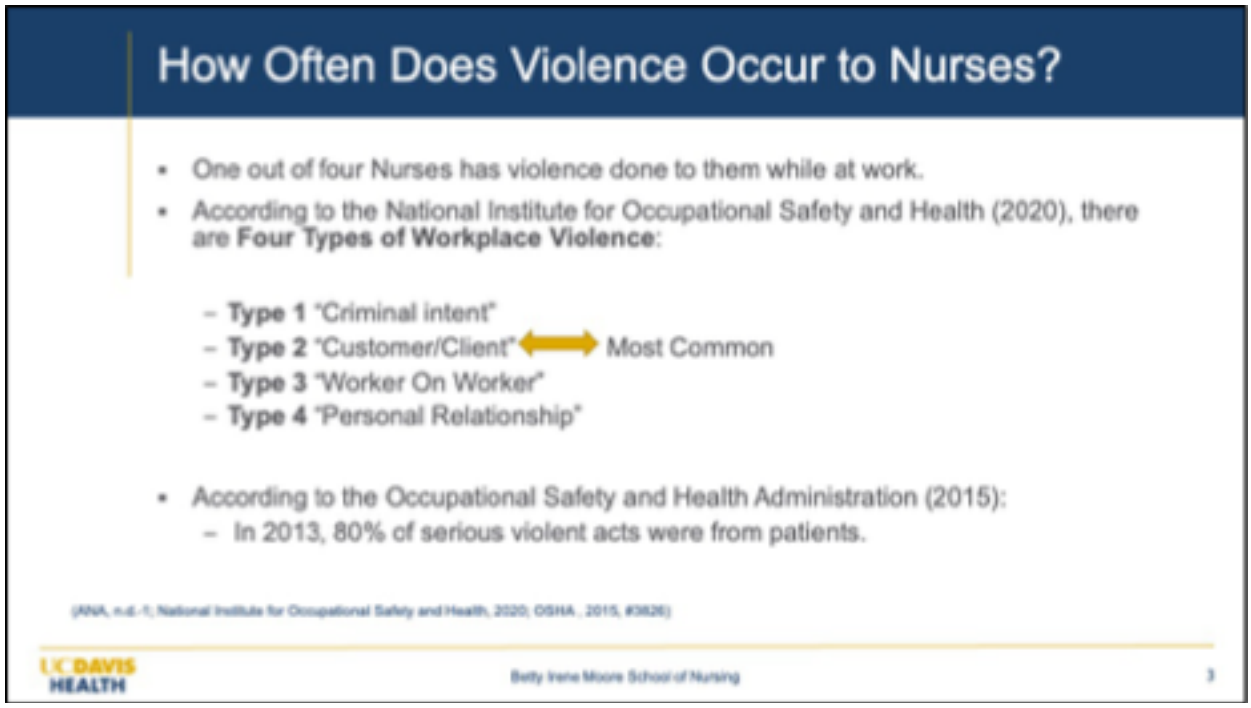
The scenario presented here with Ms. Smith yelling and throwing her lunch plate at her nurse is unfortunately an example of violent acts that happen far too often today.



-Today, we will cover the topic of Workplace Violence Prevention, as this is an educational offering, for the Medical Surgical Telemetry Nurse.

Upon completion of this learning module, you will be able to:

-Describe the prevalence of workplace violence towards nurses.
-Define the types of workplace violence nurses experience.
-Explore the impact of workplace violence on both nurses and patient care.
-Outline the 6-items of the Broset Violence Checklist.
-Apply the Broset Violence Checklist to a case study.



How Often Does Violence Occur to Nurses?

The American Nurses Association (2021) notes that 1 in 4 nurses has aggression or a violent act exhibited to them in the workplace setting.

According to the National Institute For Occupational Safety and Health (NIOSH), they define the types of workplace violence as 4 types of violence.

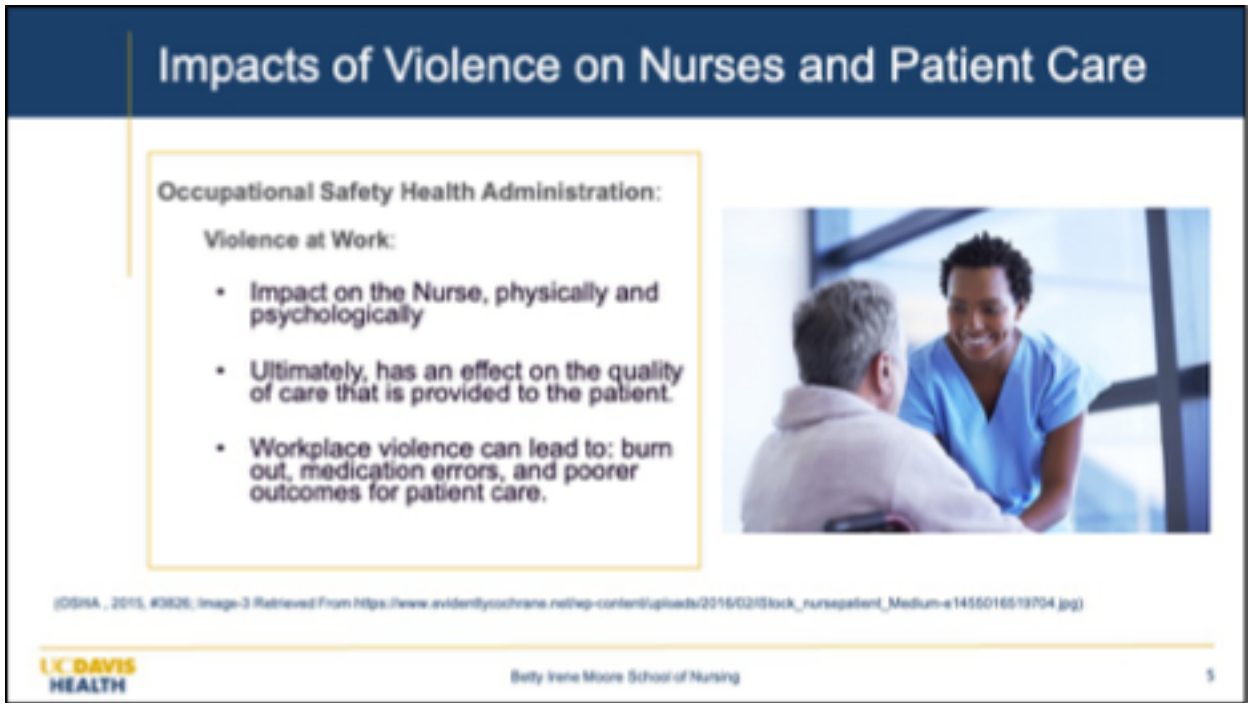
Type 1 “Criminal Intent”, Violence from someone that is not employed by the organization or company with the goal to do a criminal offense.
Type 2 “Customer/Client (patient)”, “Is the most common type of workplace violence”, The National Institute For Occupational Safety and Health (NIOSH) states this type of violence is called “Client-On-Worker-Violence” which includes patients, family members of patients, and or visitor's of patients.
Type 3 “Worker on Worker”, Violence that can take place amidst coworkers.
Type 4 “Personal Relationship”, Violence towards the nurse, stemming from a form of a personal relationship of the nurse.

With Type 2 “Customer/Client from patient” being the most common form of workplace violence on nurses.

According to the Occupational Safety and Health Administration, in 2013, 80% of serious violent acts were from patients.

According to the American Nurses Association, the definition of workplace violence is an action or threat of:

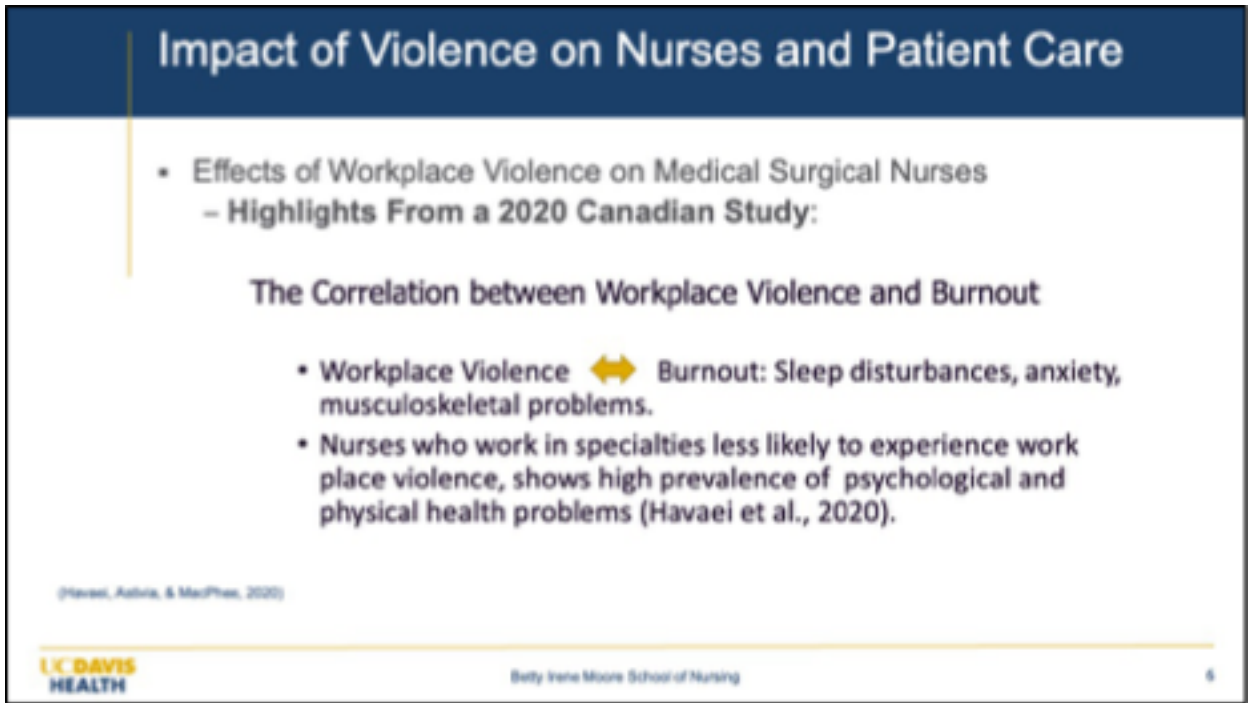
Physical violence in nature
Harassment
Intimidation & Other Threats (written or verbal) Disruptive
Psychological
Sexual in nature



You might ask? Why should I care and how does workplace violence impact patient care?

According to the Occupational Safety Health Administration, Workplace violence effects the nurse physically and psychologically, which ultimately, impacts the quality of care provided to patients.

Workplace violence can lead to: nurse burnout, medication errors, and overall poorer patient outcomes.

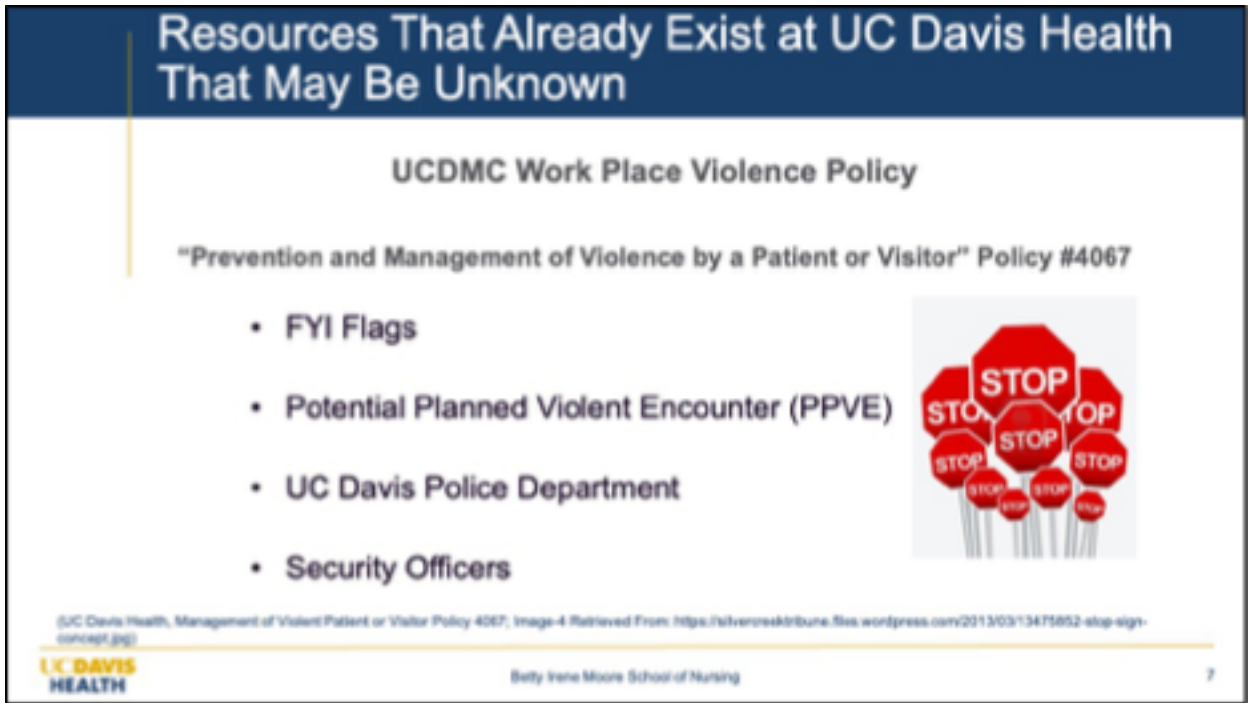


-A Canadian Study by Havaei, Astivia, & MacPhee discusses the psychological and physical effects that workplace violence has on Medical Surgical Nurses. A total of 537 nurses were included in the study.

The study's conclusion indicates that burnout can result as one of many of the psychological effects of workplace violence in nurses. Some of the main manifestations that surfaced in nurses were: "sleep disturbances, anxiety, and various musculoskeletal injuries" (Havaei et al., 2020, p. 1).

This study brings to light the correlation between workplace violence leading to burnout. Furthermore, burn out leading to physical health issues like complaints of musculoskeletal problems and psychological problems like the Medical Surgical Nurses reporting feeling more anxious and having increased sleep problems—all leading to burnout.

-Another major lesson from this study is that the authors pointed out that nurses who were less likely to expect violence to occur at work were at a greater chance of mentioning having an increased traumatic experience than nurses working in specialties where workplace violence might be more anticipated.

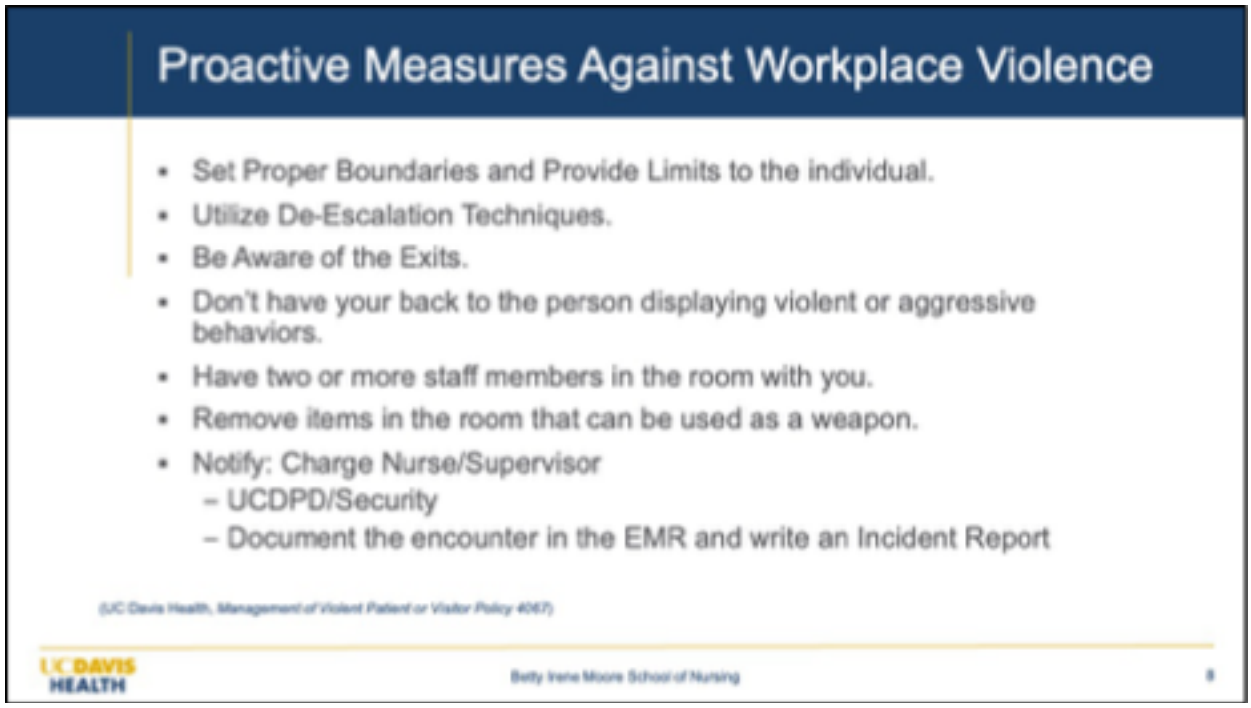


The UC Davis Medical Center Work Place Violence Policy #4067 titled "Prevention and Management of Violence by a Patient or Visitor":

Is a useful resource meant to assist staff in navigating through the process of how to deal with violent patients or visitors of patients towards staff. Its imperative that nurses are empowered with where to access the tools when necessary.

It Includes tools that might be unknown by nurses such as:

- FYI flags in the EMR
- Potential Planned Violent Encounter (PPVE)
- UC Davis Police Department
- Security Officers

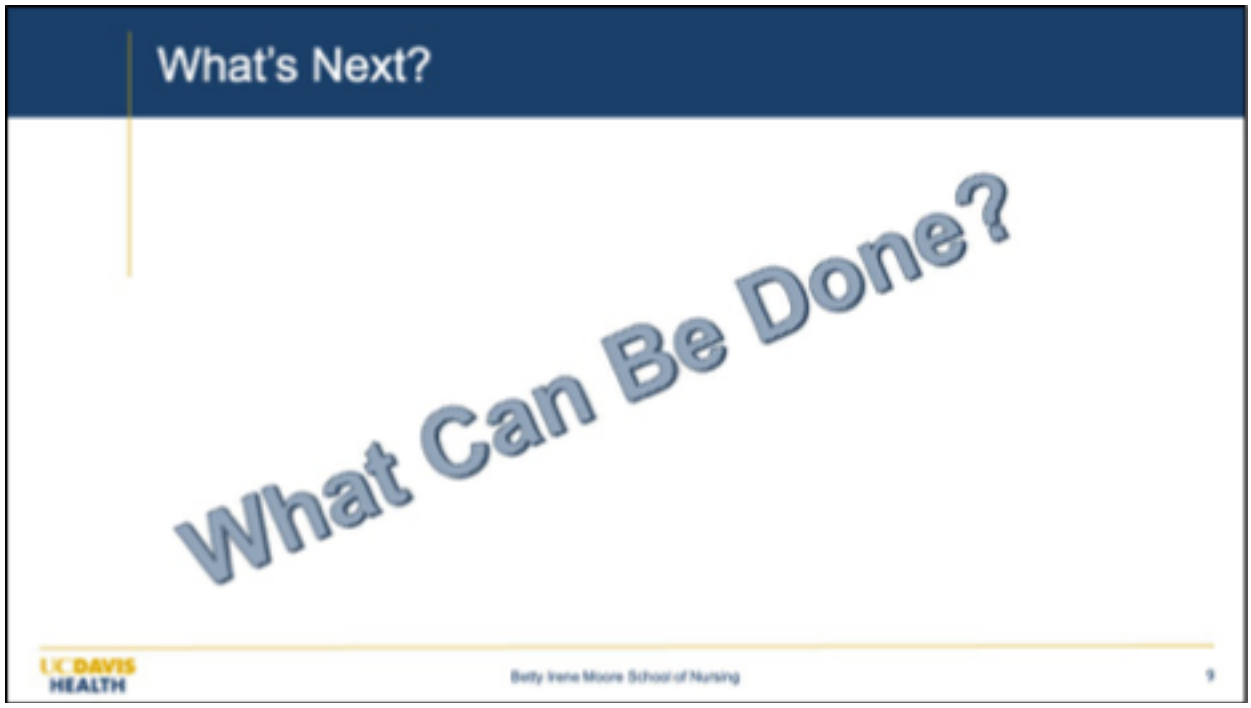


The Work Place Violence Policy #4067

Is a useful resource meant to assist staff in navigating through the process of how to deal with violent patients or visitors of patients. Its imperative that nurses are empowered with where to access the tools when applicable.

It includes Proactive Measures Against Workplace Violence:

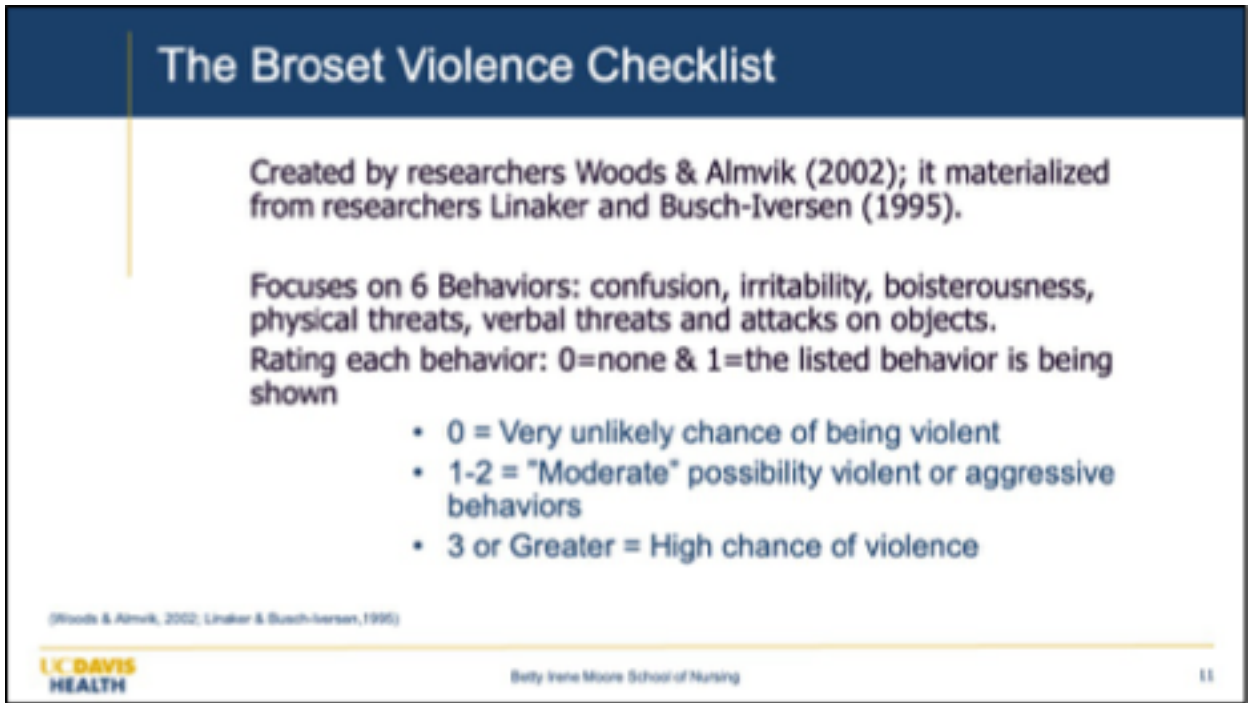
-Set proper boundaries and provide limits to the individual
-Utilize de-escalation techniques
-Be aware of the exit
-Don't have your back to the person displaying violent or aggressive behaviors.
-Have two or more staff members in the room with you
-Remove items in room that can be used as a weapon
-Notify:
Your Charge Nurse/Supervisor
UCDPD/Security
Document the encounter in the EMR and write an Incident Report



What can be done?

Prevention and actively assessing our patients shows great success in early detection. Furthermore, the ability to implement early interventions are important.

The Broset Violence Checklist is a 6-item checklist short assessment tool used to actively assess patients for potential violent acts within 24 hours during shifts.

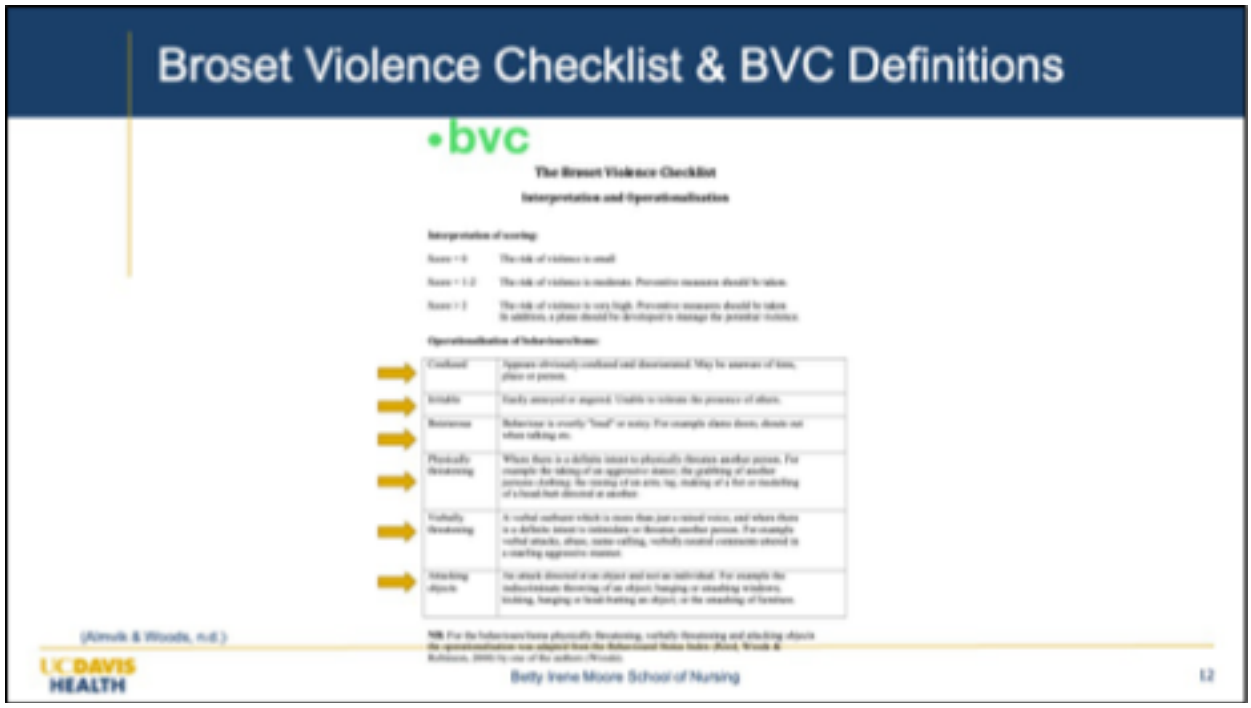


The Broset Violence Checklist:
• Was created by researchers Woods & Almvik in 2002; it was derived from the work of researchers Linaker and Busch-Iversen in 1995.

The Broset Violence Checklist: Focuses on 6 behaviors: confusion, irritability, boisterousness, physical threats, verbal threats and attacks on objects.

Rating each behavior with: 0=None & 1=For the listed behavior being shown.

The total points mean:
0=Very unlikely chance of being violent.
1-2= “Moderate” possibility of violent or aggressive behaviors.
3 or Greater=High chance of violence.

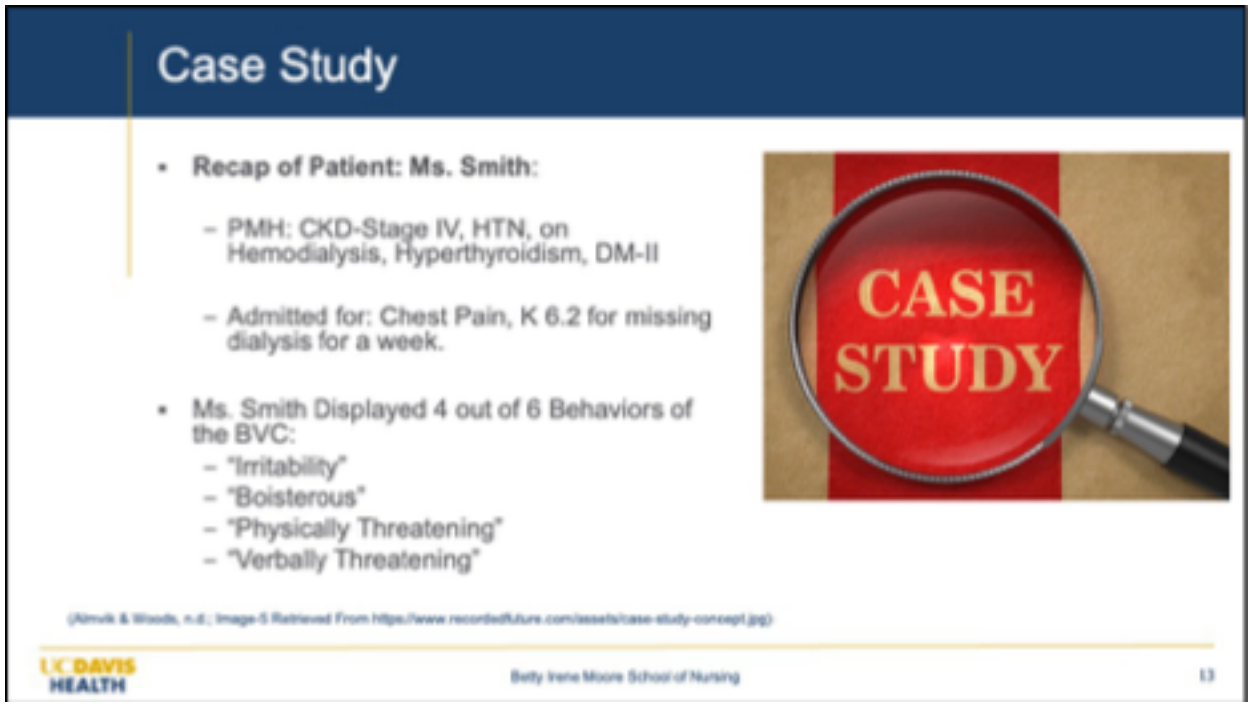


Here is a screenshot of the BVC tool from the researchers who created the tool.

Retrieved from http://www.riskassessment.no/ (Woods & Almvik, 2002).

Here are the Definitions of the 6 Behaviors from the BVC:

-“Confused: Appears obviously confused and disorientated. May be unaware of time, place or person.”
-“Irritable: Easily annoyed or angered. Unable to tolerate the presence of others.”
-“Boisterous: Behaviour is overtly "loud" or noisy. For example slams doors, shouts out when talking etc.”
-“Physically threatening: Where there is a definite intent to physically threaten another person. For example, the taking of an aggressive stance; the grabbing of another persons clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.”
-“Verbally Threatening: A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.”
-“Attacking Objects: An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture."



In the beginning of the module, we briefly discussed the situation where your patient:

Ms. Smith, a 58 year old woman with a past medical history of: CKD-Stage IV, HTN, Hemodialysis, Hyperthyroidism, DM-II was admitted to the hospital for chest pain and hyperkalemia with a K of 6.2, for missing dialysis for a week.

Ms. Smith got upset with you, her day shift nurse, when you tried to administer her scheduled Renvela. She started yelling at you and she threw the plate at you, and says "if you interrupt me again while I'm trying to eat, I will hit you again".

Ms. Smith is displaying 4 out of the 6 behaviors of the BVC:

"Irritability": Because she quickly displays anger.
"Boisterous": Since the patient is evidently yelling at you.
"Physically threatening": The patient throwing an object at you.
"Verbally threatening": Showing aggressive behaviors and verbally threatening you.

Equally a score of 4 meaning there is a high chance of Ms. Smith displaying violence again in the next 24 hours. Statistics show that violent episodes like with Ms. Smith happen at the bedside far too often and a tool like the BVC allows nurses to document behaviors observed and for interventions to be implemented to keep patients and nurses safe so that nurses can continue to provide compassionate high- quality care.

In closing:
-Workplace violence is not a part of the job.
-Take all threats and actions displayed in a violent nature seriously.
-Familiarize yourself with resources to prevent workplace violence, so you know what to do if you encounter some form of violence.

This is the end of the module. Thank you for your continued service, hard work, and dedication to providing high-quality patient care.

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

-Maya Angelou

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Image-1. Retrieved from: http://www.londongoods.co.uk/ekmps/shops/bracey76/images/takeaway-led-sign-ldx-29--54-p.jpg

Image-2. Retrieved from: https://www.wfvq.com/wp-content/uploads/2019/02/Electric-Shock.jpg

Image-3. Retrieved from: https://www.evidentlycochrane.net/wp-content/uploads/2016/02/iStock_nursepatient_Medium-e1455016519704.jpg.

Image-4. Retrieved From: https://silvercreektribune.files.wordpress.com/2013/03/13475852-stop-sign-concept.jpg

Image-5. Retrieved From: https://www.recordedfuture.com/assets/case-study-concept.jpg

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