The Broset Checklist: A Pilot Study for Patients at Increased Risk for Violence – Identification and Intervention

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Background

Violence against healthcare workers is on the rise (Watson et al, 2020). Workplace violence (WPV) is a primary focus of current regulatory agencies such as the Joint Commission. Exposure to WPV can negatively impact ability to provide effective patient care contributing to psychological distress, job dissatisfaction and early burnout, high turnover, lower retention rate, and increased costs (TJC, 2021). The Broset violence checklist (BVC, **Figure 1**) is an evidence-based risk assessment tool used to predict inpatient violence (Anderson et al, 2019).

Methods

- In November 2021, Lahey Hospital and Medical Center (LHMC) formed a multidisciplinary Workplace Violence Prevention Committee (WVPC) *"for the development and implementation of the practices, policies, training and supports needed to maintain a safe, non-threatening environment for all colleagues, patients, visitors and others."*
- With support of IT and nursing leadership, the BVC was incorporated into the electronic medical record (Epic) and educational material was created.
- In May 2023, the WVPC began a three-month pilot study on two selected units (one intensive care unit and one combined "progressive care" and general medicine/surgical unit).
- Patients that screened positive received the interventions shown in **Figure 2**.
- Using EPIC data, we examined ICD codes, timing of psychiatry consults relative to Broset scores, and use of antipsychotics and restraints before and after consults.
- Lastly, we implemented a before/after nursing survey on perceived competence towards managing violence.

Figure 1. Broset Violence Checklist and Score Interpretation

Score=0	Risk of violence is small
Score=1-2	Risk of violence is moderate. Preventative measures should be taken
Score=3+	Risk of violence is high. Preventative measures should be taken and plans for how to manage potential violence made
Confused	Appears obviously confused and disoriented. May be unaware of time, place, person.
Irritable	Easily annoyed or angered. Unable to tolerate presence of others.
Boisterous	Behavior is overtly 'loud' or noisy. For example, slams doors, shouts out when talking etc.
Physical Threats	Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another person's clothing; the raising of an arm, leg, making of a fist or modelling of a head-butt directed at another.
Verbal Threats	A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.
Attacking Objects	An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.

Figure 2. Interventions

Staff interventions for positive Broset score included:

- Pre and post nursing surveys
- Signage outside patient room
- Pop up alert in patient chart in Epic if score >3
- Notify Security
- Buddy System when entering patient room
- Consider Psychiatry consult if score >3

Results

- 882/927 (95.2%) of medically admitted patients were screened during pilot (May 30-Aug 7)
- 25 patients (2.8%) screened positive with Broset score ≥3. Avg age: 68.3 ± 3.0 years (range 38-90).
- 17/25 (68%) of BVC-positive patients were diagnosed with delirium during their stay. Those same patients also all (100%) had dementia.
- 10/25 (40%) of BVC-positive patients received psychiatry consults for the following indications:
  - 3/10 – agitation in delirium
  - 4/10 – depression/SI (one was delirious)
  - 2/10 – opioid withdrawal management
  - 1/10 – patient declined consult
- Half of such consults (5/10) were actually placed BEFORE the positive BVC screen with a range of -78 to 640 hours between BVC score and order. There was no obvious connection between BVC score and consult.
- Pre/Post survey results showed a trend towards nurses feeling more safe and confident in identifying and caring for a patient at risk for potential violence
- Nurses reported the tool was quick and easy to use, with the following quotes:
- *"During a float, I was unable to get support from a physician for an agitated patient. The patient was scoring on the Broset scale and triggering security response to bedside. Thereafter I was able to receive physician support."*
- *"I felt like security presence was significantly improved."*
- *"Security was aware of potentially dangerous patients and they rounded regularly to check in"*

Discussion

Violence in the inpatient setting is increasingly becoming a focus of hospitals across the country and psychiatry consultation services are often relied upon to help manage difficult interpersonal situations involving risk of harm. Our initial hypothesis that adding a screener to identify patients at increased risk of interpersonal violence would increase psychiatry consult volume was not reflected in the data. Nursing appeared to feel more competent in engaging patients with increased risk of violence. A full scale roll out of the BVC across our institution will hopefully address the question of whether proactive psychiatric consultation can reduce such risk.

Conclusions and Next Steps

We believe that this pilot supports the implementation of the BVC across our institution without significant consequences to psychiatry consult volume.

References

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