

Patient Care News/Department Newsletter Update

Aggressive Behavioral Management FMEA Committee

*Submitted by: Joy Plamann, BSN, RN BC, Care Center Director Medicine,
Chairperson Behavioral FMEA Committee*

Last year many departments throughout St. Cloud Hospital saw an increase in verbal and physical assaults by patients to staff. This trend caused alarm on behalf of staff, leaders and administration. As a result, a multi-disciplinary group was formed consisting of the following staff:

- Alice Frechette, Performance Improvement Director
- Paul Reisdorf, RN, Nursing Supervisor, Float Pool
- Kate VanBuskirk, RN, Coordinator Float Pool
- Paul Schoenberg, RN, ETC
- Jeremy Angell, Coordinator, Lab Support Services
- Bridgette Worlie, RN/Educator, Children's Center
- May Schomer, RN, Rehab
- Jessica Jacobson, RN, Surgical Unit
- Kirsten Skillings, RN, CNS, ICU
- Bill Becker, Safety and Security
- Ann E. Ohmann, RN/Case Manager, MHU
- Karen Miller, RN/Case Manager, MHU
- Karen Witzman, RN, EHS
- Tasha Huls, LPN, Neuroscience/Spine
- Tiffany Omann-Bidinger, RN, Dept. Dir, Neuro/Spine
- Jodie Henderson, RN, Medical Unit 1
- Steve Vincent, PhD, MHU
- Sara Meemken, Pharmacy
- Renee Warzecha, PCA, Float Pool
- Melanie West, PCA, Intensive Care
- Brandon Kime, Human Resources
- Joy Plamann, BSN, RN, BC, Care Center Director Medicine, Task Force Chairperson

The task of the committee was to conduct a FMEA (Failure Mode Effect Analysis). A FMEA is a procedure for analysis of potential failure modes within a system. Items are classified by the severity and the likelihood of the failures. This procedure helps to identify issues in current processes and helps determine where time and effort should be spent on process enhancements.

Through this process, the group identified many opportunities for improvement that are currently being worked on and others that will be evaluated in the future. Current action plan areas for the group consist of the following:

- Creation of a dashboard listing the number of events that occurred (see attached);
- Trial of a safe-environment checklist for PCAs who are completing a 1:1 on a patient;
- Evaluation of the literature surrounding this topic;
- Mandatory education for all SCH staff regarding safety practices (begins December 2011);
- Mandatory education for SCH patient care staff regarding event reporting, managing behaviors and interventions (begins December 2011).

St. Cloud Hospital is not alone with the increase in concerning events. “This year is on track to be the most violent year on record in U.S. hospitals”, reports The Advisory Board (October 20, 2011). “In the first half of 2011, the Joint Commission recorded 23 violent incidents at hospitals and long term care facilities. At that pace, 2011 will exceed the record of 42 incidents reported in 2008” (The Advisory Board; October 20, 2011).

How can you help?

You can help by reporting events as they occur. This will assist in identifying the types of events that are occurring and what the triggers may be. Secondly, if you have concerns or suggestions related to this topic, please bring them forward to a task force member. The committee will provide periodic updates related to its work throughout the year so you can continue to be informed on this topic.