

IMPLEMENTING STANDARDIZED AGGRESSION SCREENING FOR RESIDENTS IN A
RURAL LONG-TERM CARE FACILITY: A QUALITY INITIATIVE

by

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of the requirements for the degree

of

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in

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To my wonderful children and the remarkable women who have shaped my life and inspired my journey. My beloved children, Camie, Tain, Bailey, Logan, and Zayda, you are my greatest motivation and joy. Your curiosity and laughter remind me of the beauty of learning and the importance of pursuing our dreams. This work is dedicated to you, with the hope that it inspires you to reach for the stars and believe in yourselves. To my mom, Lisa Day Child, your love and sacrifices have laid the foundation of my aspirations. Your strength and resilience continue to inspire me every day, reminding me to pursue my dreams with passion and determination. To my grandma, Constance Yellowtail-Jackson, your stories and life lessons have instilled in me the values of hard work and perseverance. Your unwavering faith in me has been a constant source of motivation. Each of you played an integral role in my journey, and I am forever grateful for your love and support. This achievement is as much yours as it is mine.

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ABSTRACT

Background: There is a high prevalence of aggressive behavior in late life that has significant consequences for older adults, their caregivers, and healthcare professionals. Aggression in residents and patients in acute and long-term care facilities is dangerous for both the residents/patients and the staff. It is vital to detect aggressive crises early and intervene in order to reduce adverse health outcomes. The use of the evidence based Aggressive Behavioral Risk Assessment Tool-Long term care (ABRAT-L) upon admission to a long-term care facility may help staff recognize individuals ahead of time and plan for useful interventions to better help meet their needs.

Local Problem: A rural long-term care facility in Montana elected to implement a standardized process for administering ABRAT-L assessments to their residents.

Methods: The Iowa Model guided the implementation process over eight weeks.

Intervention: Nursing staff administered an ABRAT-L assessment to eligible residents during their admission process. An ABRAT-L ≥ 4 triggered the nursing staff to notify the physician and begin prescribed interventions. Data was collected and deidentified before entry into a spreadsheet for further analysis.

Results: The project site had ten newly admitted residents that met the eligibility requirements for the ABRAT-L screening during the eight-week implementation period. Of the ten newly admitted residents, the charge nurse screened ten (100%) of identified eligible newly admitted residents. There were 13 residents who could have been screened during their quarterly assessments; however, screenings did not happen due to staffing/time constraints. Of the ten residents who completed an ABRAT-L, four screened positive for aggression risk with a score of four or greater.

Conclusion: The findings supported the inclusion of the ABRAT-L's into assessments to aid in identifying resident aggression risk within a long-term care setting. Offering the ABRAT-L assessment improves the quality standards and allows early intervention for residents who may not otherwise receive treatment. The ABRAT-L assessment tool aims to enhance mental health care delivery and outcomes in a rural long-term care facility setting.

CHAPTER ONE

REVIEW OF THE LITERATURE

Introduction

Background

A high prevalence of aggressive behavior in late life has significant consequences for older adults, their caregivers, and healthcare professionals. Aggressive behaviors are concerning due to serious consequences, such as serious injury and death. Age-related changes in aggression manifestations can be triggered by cognitive impairment (Ravyts et al., 2021). By age 65, up to 1-2% of individuals meet the criteria for a mild or major neurocognitive disorder; by age 85, the number increases to 30% (American Psychiatric Association, 2013). Aggression in residents and patients in acute and long-term care facilities is dangerous for both the residents/patients and the staff.

Cognitive and personality changes associated with dementia can exacerbate an individual's tendency towards aggression (Islam et al., 2019). Individuals with neurocognitive impairment disorders are five times more likely to display aggressive behavior (Yu et al., 2019). Aggression in older adults with dementia is often characterized as resistance to care or agitation and usually occurs during personal care activities or when the person is in pain. A healthy older adult who attempts to avoid confrontation may also exhibit aggressive behavior in acute care settings or long-term care facilities (Ravyts, et al., 2021).

Assessment of changing behaviors can benefit from psychometrically reliable assessment tools (Ravyts et al., 2021). Residents and staff safety can be increased through targeted

preventative interventions. A simple, straightforward assessment tool can identify residents at risk of aggression before those events occur. When staff is able to recognize aggressive behaviors in residents and meet their physical and psychological needs promptly, aggressive behaviors may be prevented (Kim et al., 2019). The use of the evidence based Aggressive Behavioral Risk Assessment Tool-Long term care (ABRAT-L) upon admission to a long-term care facility may help staff recognize individuals head of time and plan for useful interventions to better help meet their needs.

There is a widespread problem of resident/patient violence in healthcare settings (Lim et al., 2022). Nurses lack brief screening tools for identifying those who may be at risk for violent behavior. To predict violent behaviors during admission, an assessment tool with satisfactory psychometric properties is needed (Kim et al., 2011). The residents of a rural long-term care facility located on a Montana reservation are not currently screened for aggressive behavior. As a result, there have been many episodes in which residents have attacked other residents and/or staff. This has resulted in injury and the need for further investigation by multiple state agencies.

Failure to screen during admission to long-term care facilities may result in residents' aggressive behaviors being missed, putting residents and staff at physical and emotional risk. Without aggression screenings, staff are not prepared to handle an aggressive resident with proper interventions. There is increased aggression seen in long-term care residents. According to Kim et al., (2019) approximately 1.4 million Americans reside in long-term care facilities and approximately half of them suffer from neurocognitive disorders. Dementia-compromised behavior models suggest that aggressive behavior is triggered when a resident's needs go unmet (Yu et al., 2019) Improving residents' and staff's safety might be possible with a tool to identify

residents at risk of aggression before it happens. Staff can prevent aggressive behaviors by anticipating and meeting residents' physical and psychological needs (Kim et al., 2019).

The Aggressive Behavior Risk Assessment Tool (ABRAT) was designed to identify potentially aggressive patients with or without dementia upon admission to acute care units (Kim et al., 2011). Kim et al., (2011, 2022) and Berry et al (2017) implemented the ABRAT-L assessment and tested it in long-term care facilities to assess its utility in predicting aggressive incidents among residents. The ABRAT-L assessment is proposed for implementation at the identified long-term care facility.

Identifying potentially aggressive residents with a validated risk assessment tool may enable targeted interventions. An easy-to-use tool called ABRAT-L may be used as part of routine assessments of new residents in long-term care facilities (Kim et al., 2017). The ABRAT-L tool is being proposed for implementation at this long-term care facility in rural Montana. The scoping review of literature presented here will provide evidence to support the use of the ABRAT-L in a long-term care facility, however it is important to note the facility of interest is a unique setting. The long-term care facility serves rural Indigenous patients. The ABRAT-L has not been established for use in Indigenous populations and while this project does not intend to provide reliability and validity testing for the ABRAT tool in Indigenous populations, it is my hope the tool will be able to successfully be deployed, and culturally sensitive interventions will be implemented for this unique population.

Methods

Overview

The literature search examined the ABRAT tool for its effectiveness and applicability in various healthcare settings, including medical-surgical units, emergency departments, and long-term care facilities. The purpose of the review was to evaluate the reliability, sensitivity, and specificity of ABRAT and its modified versions known as the for identifying residents at risk for violent behavior. The review also intended to establish if modifications made to the ABRAT tool increased usability in target patient groups. Specifically, I wanted to know if the ABRAT provided useful data in a range of clinical settings including medical-surgical units, with older adults in long-term care, and patients in acute mental health settings. The ABRAT tool used in long-term care facilities is known as the ABRAT-L assessment.

Search Strategy

The scoping review examined the use of the ABRAT assessment use in various healthcare settings for predicting aggressive incidents among patients and residents in acute and long-term care settings. The articles included in this scoping review were identified through a systematic search of various peer-reviewed literature databases such as PubMed, Cochrane, and Cumulative Index to Nursing and Allied Health Literature (CINAHL). Reference lists of various articles were reviewed to find additional relevant articles. These searches were conducted during August and September of 2024. The following terms were used in the search: “ABRAT” AND development, “ABRAT-L” AND “ABRAT survey” and “ABRAT ED” and “Aggression Tools” and “Aggression Screening Tools”.

Inclusion Criteria

To be included in this scoping review, articles must have been peer-reviewed and published within the last 15 years, be written in English, and have full texts available online.

There are not many studies done on the ABRAT and ABRAT-L tool, which is why I decided to include articles greater than 10 years old. Articles focused on the use of aggression surveys in acute care settings were considered for inclusion. Excluded articles included non-English translations and focused on the causes of aggression in patients.

Results

Literature Search

The initial electronic search yielded 45 results, which was reduced to 23 after search criteria were entered and duplicates were removed. Articles were initially screened based on their abstracts for relevance. The remaining 13 full-text articles were assessed for eligibility and excluded based on the reasons of not being within the 15-year criteria, not being in English, and not being peer-reviewed. Seven articles remained after the articles were excluded based on the criteria. The seven identified articles focused on the validation, application, and adaptation of ABRAT. The most common study methodology was longitudinal studies.

Synthesis of the Literature

The identified studies included Kim et al. (2011) and Kim et al. (2022), which evaluated the tool in medical-surgical units and emergency departments, respectively, highlighting its robustness in hospital settings (Kim et al., 2011; Kim et al., 2022). Several studies, like Ravyts et al. (2018) and Kim et al. (2017), analyzed ABRAT's application among older adults, demonstrating its relevance in long-term care environments (Ravyts et al., 2018). Anderson & Jenson's (2019) literature review emphasized the need for tailored risk assessment tools in acute mental health settings, offering a broader perspective on their generalizability. The studies reviewed provide a comprehensive understanding of the ABRAT's application across different

healthcare settings, its reliability, and the importance of adapting the tool for specific populations.

Effectiveness of the ABRAT in Predicting Aggression A central theme across the studies is the consistent reliability of ABRAT in terms of sensitivity (ability to detect aggressive behavior) and specificity (ability to correctly identify non-aggressive individuals). The studies generally support the reliability and validity of the ABRAT in different care environments and patient populations. Kim et al. (2011) reported high specificity (89.3%) and sensitivity (70.9%) when using the tool in medical-surgical units. Kim et al. (2022) found similar strengths in emergency department settings, with an even higher sensitivity (84.3%) and specificity (95.3%). Consistency across studies indicates the ABRAT can be a reliable tool for predicting aggressive behavior across high-stress hospital environments. For long-term care settings, Kim, Berry, and Young (2018) and Ravyts et al. (2018) focused on the ABRAT-L, which has a slightly lower sensitivity (56.6%) but retains high specificity (90.8%). These studies highlight the tool's capacity for early identification of aggression despite the different patient dynamics in long-term care (Ravyts et al., 2018). The tool's higher sensitivity in specific settings indicates its ability to accurately detect a greater number of potentially violent individuals in high-stress environments, which is crucial for staff and patient safety.

Adaptation for Specific Populations A prominent theme is adapting the assessment tool based on the population being evaluated. Tool adaptability is important because it allows for a consistent assessment of aggression risk across different care settings and patient populations and overall contributes to improved safety and care outcomes. For example, Kim et al. (2011) found the ABRAT could be applied in busy medical-surgical units with good reliability (Kim et al.,

2011), while Kim et al. (2022) showed its effectiveness in the fast-paced environment of emergency departments (Kim et al., 2022). Kim, Berry, & Young and Ravyts et al. (2018) both emphasize how the tool's adaptation to long-term care settings (ABRAT-L) was essential for its effectiveness (Ravyts et al., 2018). The theme of adaptability of ABRAT is further supported by Anderson and Jenson (2019), who found general tools may lack the precision needed for specific populations, such as those in acute care mental health settings (Ravyts et al., 2018). The ABRAT-L is a modification of the original tool for long-term settings, which is important given the unique needs of older adults, such as cognitive decline and dementia. Kim et al. (2017) validated the tool's effectiveness in predicting aggression with a sensitivity of 56.6% and specificity of 90.8% (Kim et al., 2017). Ravyts et al. (2018) supported using tools like the ABRAT-L in long-term care, emphasizing the importance of adapting screening tools to accommodate the different behavioral dynamics seen in elderly populations (Ravyts et al., 2018). Anderson and Jenson (2019) highlighted the need for tools like the ABRAT to be adapted for specific populations, such as acute mental health settings. Their review stressed that while general tools can provide a baseline, tailored tools are needed to maintain accuracy and effectiveness in specialized environments (Anderson & Jenson, 2019).

Proactive Risk Management According to the findings, the ABRAT plays a crucial role in risk prevention by early identification of aggressive behavior. Berry, Young, and Kim (2017) found using the ABRAT in long-term care homes led to early identification of high-risk residents, which allowed for targeted interventions, resulting in reduced incidents of violence (Berry et al., 2017). A proactive approach was also evident in Kim et al. (2011), where the ABRAT's use in medical-surgical units helped nurses implement preventive measures for

potentially violent patients (Kim et al., 2011). Early intervention aligns with the broader goal of improving patient and staff safety across healthcare settings.

Consistency in Sensitivity and Specificity Across studies, the ABRAT consistently demonstrated high specificity, making it reliable in correctly identifying non-violent patients. This is important for minimizing false positives, where non-aggressive patients might otherwise be labeled as high-risk. The specificity was especially notable in studies like Kim et al. (2022), where a 95.3% specificity in emergency settings demonstrated the tool's accuracy (Kim et al., 2022).

Discussion

Principal Findings

The scoping review of literature identified six articles focused on the use of the ABRAT or ABRAT-L tools in a variety of settings and patient populations. From the six articles reviewed, the ABRAT tool has been demonstrated to be effective at identification of aggressive behavior risk in various healthcare settings and allows providers to implement individualized interventions before behavior becomes a problem. ABRAT demonstrates high sensitivity and specificity, accurately discriminating between those at risk of aggression and those who are not. Risk for violent episodes can be effectively addressed through early identification with ABRAT, allowing healthcare providers can be proactive with preventative measures before incidents grow to higher levels of severity.

Conclusion

While the ABRAT has been adapted to multiple care settings and patient populations, it has not been fully vetted in Indigenous populations. Although there is a lack of evidence-based research specific to Indigenous populations, I believe the established effectiveness of the ABRAT does support its use in the long-term care center of interest. The following sections will outline a process for implementation of the ABRAT-L in a long-term care facility in rural Montana.

CHAPTER TWO

QUALITY IMPROVEMENT PROPOSAL

Introduction and ProblemIntroduction

Long-term care facilities must prevent aggressive behavior among newly admitted residents. Preventing aggressive events may be possible by identifying potentially aggressive residents in advance. The Aggressive Behavior Risk Assessment Tool for long-term care (ABRAT-L) has demonstrated satisfactory accuracy in predicting aggressive behavior (Kim et al., 2019). Globally, aggression and violence in healthcare settings is growing, and health institutions worldwide must implement interventions as aggression and violence in healthcare settings remains an ongoing challenge (Davids et al, 2021). Murphy et al. (2017) found nursing home resident to resident aggression (RRA) has serious negative health implications. Aggression directed at another resident is concerning due to an increased vulnerability to death and injury, (Murphy et al., 2017). Pillemer et al. reports a high prevalence of RRA in nursing homes and is at the core of a widespread problem of negative and aggressive interactions among residents. There is a link between resident-to-resident aggression and physical harm as well as psychological distress and even death (Pillemer et al., 2024). Aggressive behavior of residents towards caregivers and staff also poses further risk to overall health and workplace safety.

On a reservation in rural Montana, aggression in a long-term care facility was a leading cause of nurses needing to contact doctors, administrative staff and families. Managing the situation and protecting residents and staff can be difficult for all parties involved but especially

for staff. In the long-term care facility of interest, staff and other residents have been physically attacked by aggressive residents, as well as verbally abused. The admission process does not include an assessment tool for measuring possible aggression, this long-term care facility could benefit from incorporating an aggression assessment tool.

Problem Statement

Aggression in healthcare is a significant problem that occurs in various forms, including verbal abuse, physical violence, and disruptive behavior. Healthcare workers, residents, their families, and healthcare organizations all care about the safety and well-being of all effective care. Aggression is a problem in healthcare because it impacts multiple stakeholders' by affecting safety, quality of care, and well-being of individuals. According to Arnetz (2022), the costs associated with non-fatal workplace violence and aggression in health care settings range from \$109,000 per year for treatment and indemnity among injured nurses to over \$330,000 per year in a single hospital. Estimates do not include psychological trauma, fear, or work dissatisfaction that may occur because of workplace violence or patient-related costs (Arnetz, 2022).

Addressing the problem is essential for creating a healthier and more effective healthcare system. Implementation of an evidence-based assessment tool, such as the ABRAT-L has been shown in current literature to identify residents at risk for aggressive behaviors and allow for intervention to reduce risk and thereby improve overall safety. The validation study conducted by Kim et al. (2018) confirms the usefulness of the ABRAT-L as a routine admission assessment tool and discuss this tool had satisfactory sensitivity and specificity in predicting aggressive

events. The ABRAT-L was selected as a tool to meet the need in a rural long term care facility located on a Montana Reservation.

Organizational Microsystem Assessment

The small rural long-term care facility implementing the quality improvement (QI) project is located on a reservation in South-Eastern Montana. The long-term care facility is in a town of 1,097 citizens. In 2022, there were 27.7 times more American Indian residents on the reservation than any other race or ethnicity. There were 68 white and 16 non-Hispanic residents, the second and third most common racial groups (United States Census bureau, 2022). The most common employment sectors for those who reside on the reservation are healthcare, social assistance, public administration, and retail trade.

The long-term care facility's staff is comprised of one full-time physician and four full-time registered nurses (RNs). A social manager within the facility oversees complaints and other concerns from residents, families, and the state, but is available for any other needs residents, family and staff may have. The administrator and board members are also recognized as essential stakeholders in the day-to-day activity and function of this long-term care facility. The physician treats all residents for routine, preventative care, and chronic conditions. If the residents have an acute illness, injury or medical emergency, they are sent to the emergency department for further evaluation.

Clinical site observation and stakeholder interviews identified an overwhelming concern for the increased prevalence of aggression in residents toward other residents as well as staff at the long-term care facility. Staff were frustrated with the lack of access to interventions, especially when an aggressive resident physically or verbally attacks another resident and/or

staff. The staff is small, so the extent of care and time required for a resident in an aggressive crisis can put a strain on the overall flow of the long-term care facility, especially after hours when there is one nurse and 1-2 CNAs on shift. While there are many complex issues at play, stakeholders agree that improving aggression screenings could proactively prevent many residents from reaching a crisis state.

Presently, there are no written policies at the long-term facility regarding who, when, and how often to screen for aggression risk. There is a two-question behavior screening upon admission that is brief. The current resident admission process includes the nurse escorting the resident to their assigned room, collecting vital signs, and reviewing medications and allergies. The nurse enters the information into the Electronic Health record (EHR) during the rooming process or at their desk computer. The nurse then gives a brief verbal report to the physician on vital signs and status. Multiple screenings are done by different staff members during the admission process. The two question behavior screening is typically not completed by nursing staff during the admission process, but completed by the social manager and results of the behavior screening are not usually reported to the physician. Implementing the ABRAT-L screening during the admission process appears feasible as it is quick and easy to complete. A short screening process promotes the identification of aggression while fitting into the time constraints of resident care. The ABRAT-L allows the staff to screen this population during admission, and quarterly. The way we can capture quarterly ABRAT-L assessments is by adding it to all residents' quarterly assessments that are due by the facility. Quarterly assessments fall within all different times for each resident because it goes off their admission date. This long-term care facility has an assessment nurse that captures each residents' quarterly assessments that

are due. This may help to get the residents all assessed by the ABRAT-L who were already admitted to the facility prior to the initiation of this quality improvement project. The assessment nurse can inform the project coordinator who is due for quarterly assessments and the ABRAT-L can be done at this time.

Quality Improvement Model

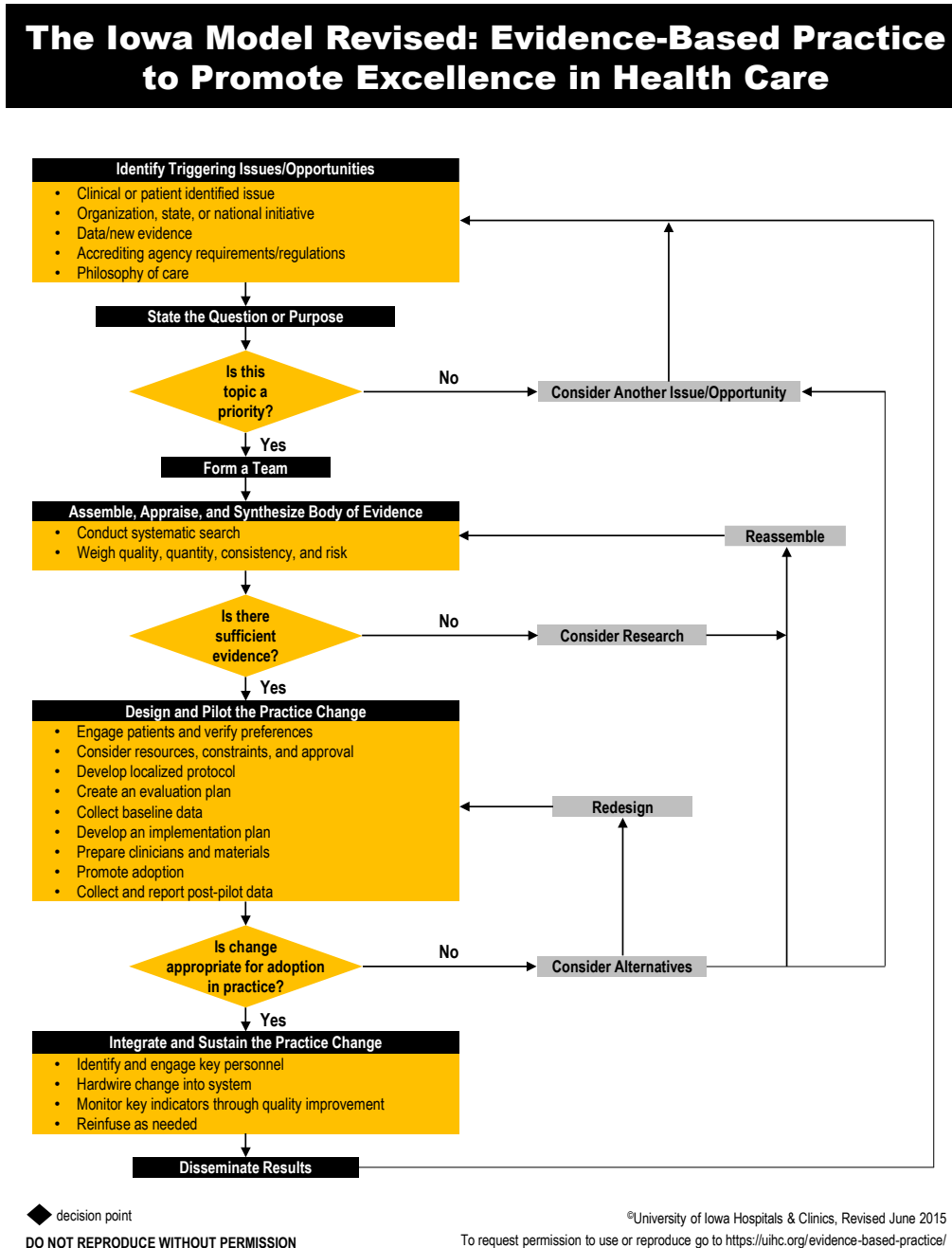
The Iowa Model will guide the development and implementation of the QI project. The Iowa Model is based on a flow chart, to assist healthcare facilities in identifying problems and making effective changes to improve outcomes (Iowa Model Collaborative, 2017). Fig. 1 illustrates the steps involved in a successful QI project. The stages are:

1. Identify Triggering Issues/Opportunities
2. State the Question or Purpose
3. Form a Team
4. Assemble, Appraise, and Synthesize a Body of Evidence
5. Design and Pilot the Practice Change
6. Integrate and Sustain the Practice Changes
7. Disseminate Results

The first stage was completed using the site observations and interviews with facility staff. The first stage determined there was a lack of standardized aggression screening for residents. During stage two, key stakeholders agreed that aggression screening could help address the concerns staff had about the worsening aggression within the long-term care facility and improve resident outcomes. Residents' health and safety were ranked top priority by stakeholders. In stage three, leadership team members and staff were recruited that would

advocate for change within the facility. The project implementation team will include the project coordinator (charge nurse), social manager, business office manager, one physician, and four nurses. Stage four was completed using a scoping review of the literature that identified the ABRAT-L as valid option for implementation. Step five was initiated by the charge nurse who organized meetings with the implementation team. During these meetings, staff provided input on what they felt was manageable and appropriate regarding workflow, scope of practice, and resident care. The charge nurse took feedback to develop a new workflow allowing adequate implementation of aggression screening during the admission process. Steps six and seven will continue to guide the QI project following proposal approval as a standardized ABRAT-L screening is implemented within the long-term care facility. The model allows us to redesign and consider alternatives as issues arise during implementation.

Figure 1: The Iowa Model Revised



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Specific Aims/Purpose Statement

The rising incidence of RRA as well as aggression toward staff in a rural Montana long-term care facility triggered the need for an improved risk identification and implementation preventative measures. The implementation of a standardized aggression screening within the project site has the potential to identify residents who experience aggression or are at risk, therefore allowing them to receive intervention before entering a crisis state. The QI project described above aims to identify risk for aggression and guide intervention implementation and lessen the strain on a small long-term care facility's limited resources.

The primary short-term goal of the project is to complete an ABRAT-L assessment on at least 85% of residents on admission during the project implementation. All residents admitted to the facility during the project will receive an ABRAT-L assessment. Residents excluded from assessment would include residents who refuse to participate. If a resident screens positive (score ≥ 4) on the ABRAT-L, next step is to refer that resident to the physician for further assessment and intervention. The second short-term goal is at least 95% of positives are referred to the physician for further assessment and intervention. Staff will be provided education on how to use the ABRAT-L tool by an in-service training with a PowerPoint and flow chart that will guide the staff on how to accurately use the ABRAT-L tool. The ABRAT-L tool consists of six questions; a positive result is if the resident scores 4 or greater. To accurately evaluate outcomes, staff must also ensure ABRAT-L screenings are placed in the appropriate folder so chart audit can be completed. The physician will complete an assessment on positive screens and interventions will be implemented as deemed appropriate by the physician. The intermediate goal is that the

physician will assess 95% of positive screens and work with staff for targeted interventions to decrease risk.

The long-term outcomes of this project rely heavily on the success of the short-term and intermediate goals. The ideal long-term outcomes resulting from this project are a decreased incidence of aggressive behavior related to physical and verbal abuse displayed by residents to other residents and to staff. The ability to evaluate the long-term outcomes goes beyond the scope of this QI project due to time constraints.

Intervention and Implementation

Implementation Summary

A small rural long-term care facility on a reservation in South-Eastern Montana has identified implementing standardized aggression screening as a priority intervention following a steady rise in residents presenting with an acute aggression. The QI project was developed following a systematic review of the literature, multiple site visits, and stakeholder interviews. The primary intervention requiring implementation is the standardized use of the ABRAT-L. Nursing staff and social services staff will complete the screening on all residents during their admission process, and if the resident has a history of aggressive events towards staff and other residents. Residents with positive ABRAT-L screenings will be referred to the facility physician for assessment and further evaluation of risk for aggression. Early intervention and treatment can prevent harm to other residents and staff from unknown aggression. The ABRAT-L screening tool can improve residents' outcomes as well as decrease the strain on staff. The project implementation will occur over eight weeks, followed by data review and analysis.

Intervention and Implementation.

The rural long-term care facility site will participate in the implementation of standardized ABRAT-L screenings to promote early recognition and treatment for residents experiencing aggression. The implementation plan is outlined below.

Stakeholder Buy-In. To be successful, QI projects must have stakeholder support and belief. A preliminary meeting has been held to gauge interest and collect feedback on the improvement process. To understand the purpose of the intervention and how the screenings should be administered, four nurses and one physician will attend a training session.

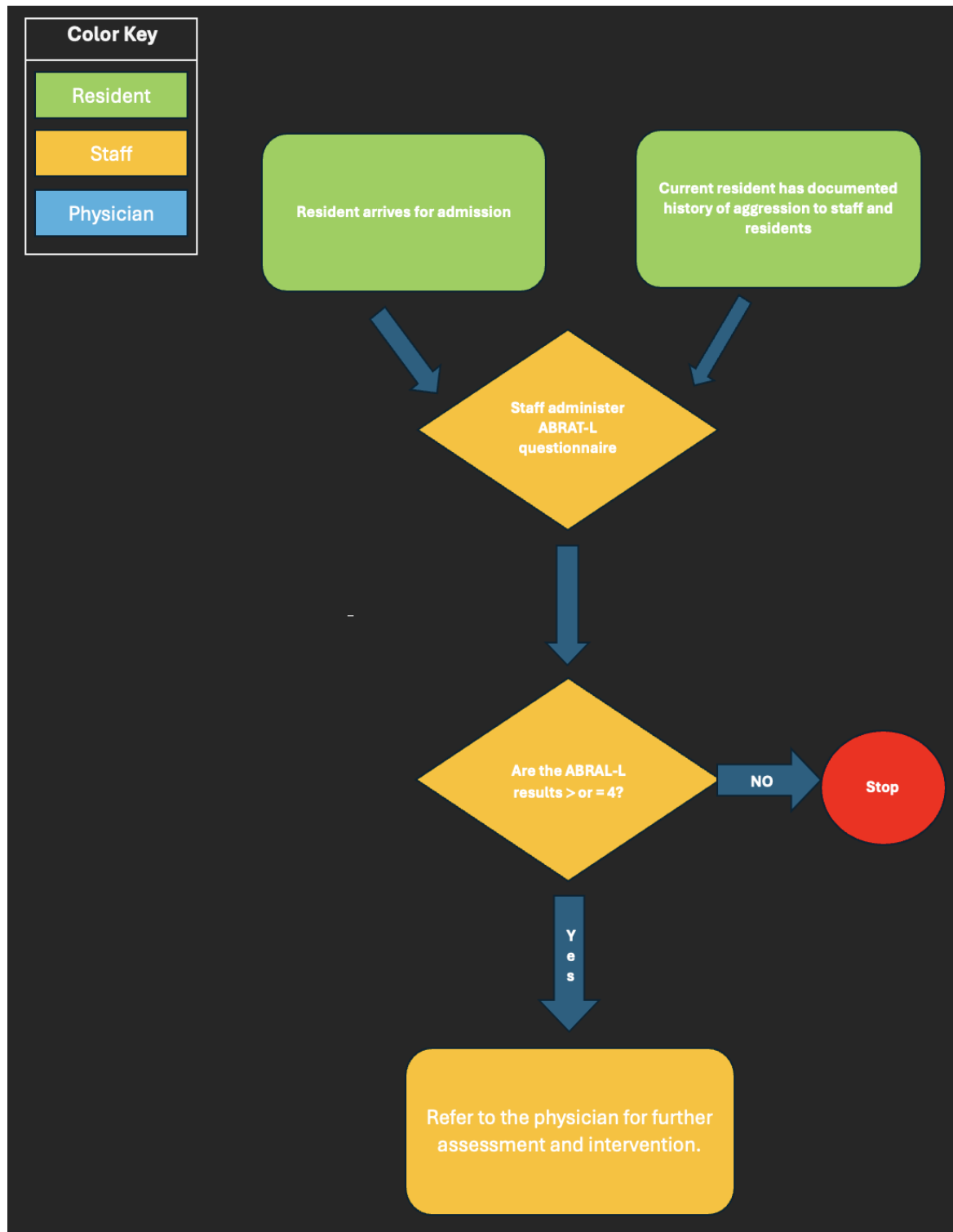
Implementation Plan. All staff will be educated on the how to properly administer the ABRAT-L assessment to residents. A PowerPoint will be used to introduce the ABRAT-L tool and how it is scored. A flow chart will be used to guide the staff if a positive is identified. Education will also be provided on what to do with a positive assessment, which is positives are referred to the physician for further assessment and intervention. All residents will receive a hard copy of the ABRAT-L survey from their nurse or social services manager during the admission assessment. The nurse will review the answers at the end of the interview and determine if the resident has a positive screening of ≥ 4 . If a resident has a positive ABRAT-L, the resident will be referred to the physician for further assessment and intervention. The total weighted score ranges from 0 to 8, with 4 and above indicating a high level of aggression (Kim et al., 2019). Among the items on the scale are factors associated with increased aggression likelihood, such as cognitive impairment, anxiety, and aging. The process is summarized using a flow chart developed by the project coordinator with stakeholder input and is provided below in Figure 2.

Barriers

Table 1: Potential Barriers and Solutions

Potential Barrier	Potential Solution
Resident refusal	Residents are always able to refuse ABRAT-L screenings and/or treatment for aggression. Education of untreated aggression will then be provided to the resident.
Cultural and language	Staff may lack cultural competence, impacting their ability to effectively communicate with patients from diverse backgrounds about aggression. Language differences can hinder communication.
Time constraints	The ABRAT-L was chosen as the primary interventions because it is short and simple causing minimal extra time to be taken conducting this survey. However, if a resident screen positive the staff should prepare to take time to address the resident's aggression.

Figure 2: Proposed Aggression Screening Flowchart



Evaluation and Analysis.

Process compliance and data collection will be completed weekly by the project coordinator. The project coordinator will gather ABRAT-L assessment documents completed that week and compare questionnaires collected to the new admission records and EHR documentation. The project coordinator will conduct chart audits during this period to ensure positive screenings receive a physician assessment within 48-72 hours. Additionally, an informal check-in process will be implemented, during which the project coordinator will ask staff about the interventions and any challenges they have encountered. To gather qualitative data regarding the process from the perspective of the staff, a formal stakeholder meeting will be held every month to follow-up on the staff administering the ABRAT-L assessment and if they have any questions or concerns regarding the use of this tool.

Every week, the project coordinator, the charge nurse, will enter quantitative data including number of residents who meet qualifications during the project timeline, number of residents who scored ≥ 4 on the ABRAT-L survey, number of residents who were referred to the physician for further assessment and intervention into a spreadsheet. Data on demographics will not be collected or entered into the spreadsheet. To monitor changes and trends in data, plot points will be added each week to a run chart. To summarize the data collected, descriptive statistics will be expressed as percentiles. The following tables provide examples of descriptive statistical categories based on SMART goals.

Table 2: SMART Goal #1

SMART Goal #1: An ABRAT-L is completed on at least 85% on all residents who meet qualifications during the project timeline.		
- Residents not qualified for screening are those refuse or if their power of attorney refuses. - Nursing staff and social services manager provide resident with written ABRAT-L and collect completed assessment. - An ABRAT-L score ≥ 4 triggers need for physician assessment within 48-72 hours - All completed assessments are placed in folder kept by director of nursing. - Project coordinator collects assessments from folder and compares completed assessments with resident schedule on a weekly basis. - Data is deidentified and entered by project coordinator into spreadsheet.		
Data to be collected	Method of collection and who is responsible	Planned data analysis
Number of total residents. Number of residents who qualified for screening by newly admitted or history of aggression. Number of qualifying residents	Responses to ABRAT-L are collected on paper by nursing staff and social services manager are then placed in folder kept in the director of nursing's office. Data entered into spreadsheet by the project lead.	Total residents - non-qualifying patients = total patients needing ABRAT-L Completed ABRAT-L assessments/Total residents screened = % residents screened

Table 3: SMART Goal #2

SMART Goal #2: A physician assessment is completed on all residents who score ≥ 4 on their ABRAT-L in at least 95% of cases.		
• ABRAT-L score ≥ 4 triggers requirement for physician referral and assessment • Nurse places assessment results in folder kept by the director of nursing. • The physician completes a resident assessment • Project lead collects data weekly and compares positive ABRAT-L and indicates when physician referral completed • Data is deidentified and entered into spreadsheet by project lead weekly.		
Data to be collected	Method of collection and who is responsible	Planned data analysis
Number of residents with positive ABRAT-L. Number of residents who received physician referral following positive ABRAT-L.	Nursing staff and social services manager collects both ABRAT-L and turns them into folder kept by director of nursing. Data is entered into spreadsheet by project lead.	Residents with positive ABRAT-L = % residents screened

Table 4: SMART Goal #3

SMART Goal #3: Physician will assess and provide recommendations for interventions of an ABRAT-L ≥ 4 .		
• Nursing staff will notify physician when ABRAT-L ≥ 4. • Physician will provide further assessment and intervention. • Physician will mention resident assessment of aggression in visit note. • Project coordinator will audit charts weekly that had an ABRAT-L score ≥ 4 to determine if resident assessment was completed and documented. • Project coordinator adds data to flow sheet.		
Data to be collected	Method of collection and who is responsible	Planned data analysis
Number of residents who scored ≥ 4 on ABRAT-L. Number of positive screened residents who received referral to the physician for further assessment and intervention.	Nursing staff return ABRAT-L results to folder kept by director of nursing. Physician documents assessment and diagnosis as necessary. Project lead audits charts and enters data into spreadsheet.	Residents who receive a physician assessment/ABRAT-L scores ≥ 4 = % residents screened

Table 5: SMART Goal #4

SMART Goal #4: The physician will provide orders for nursing staff for interventions to decrease aggression risk in residents the physician deems appropriate.		
- Physician will formally assess all residents who have ABRAT-L score of ≥ 4. - Residents that are diagnosed with a of mental health disorder where aggression is a symptom and score ≥ 4 are provided with appropriate treatment options. - Referrals are submitted for residents who agree to participate in interventions.		
Data to be collected	Method of collection and who is responsible	Planned data analysis
Number of ABRAT-L scores ≥ 4 . Number of residents with scores ≥ 4 who receive a formal evaluation and diagnosis of mental health disorder where aggression is a symptom. Number of residents who are offered intervention options.	Nurses return ABRAT-L results to folder kept by office manager. Physicians properly document assessment and plan of care. Physicians enter referrals for residents requiring therapy and send prescriptions for those requiring medications. Project lead audits charts and enters data into spreadsheet.	Number of residents offered treatment/Number of ABRAT-L scores ≥ 4 = % residents who received appropriate intervention Number of residents who received medication or therapy/Number of residents offered intervention = % of residents who accepted treatment

Timeline.

Data will be collected over eight weeks. Following the completion of data collection, a 2–3-week timeframe is anticipated to analyze data and make conclusions on project outcomes. There are a few items to consider that are specific to the facility that may interfere with the overall success of the project. There is only one nurse who is employed by the facility, the other nurses are temporary travelers. The employed nurse may need extra guidance or support as she is the only one who will be present the entire length of the QI project, and there is a higher likelihood of missed screenings due to the nursing staff traveler's contracts ending and new nurses starting new contracts. The number of staff is small, if someone is absent or a high-acuity resident requires additional care, there could cause a disruption in the overall workflow and ability to complete screenings. The implementation team is aware of the potential limitations and will attempt to adapt as needed to support the project's integrity.

Safety and Confidentiality

Using pen and paper for aggression assessments could increase the risk of resident health information being misplaced or misused. Due to the inability of the current EHR system to integrate a questionnaire, the only option available is to conduct written assessments. The questionnaires will be completed by the residents in their rooms with the assistance of the staff. If ABRAT-L results indicate a positive outcome, nursing staff will review them and notify the resident's physician. Once the document is delivered to the office manager, it will need to be filed in a locked filing cabinet.

The paper questionnaires will only contain the results of the ABRAT-L and the residents medical record number. Medical record numbers will be used so the project coordinator can audit

the charts to determine whether treatment was offered and if follow-up was scheduled. Once the resident's information has been collected, the paper questionnaire will be scanned and shredded immediately.

A paper file containing ABRAT-L assessments may be available to the project coordinator for the purpose of collecting data and assessing the effectiveness of intervention measures on a weekly basis. The project lead will be allowed to review only visit notes pertaining to the QI project. As the project coordinator enters the data into a spreadsheet, all information will be de-identified. The data collection and review will only take place at the facility, with no personal health information leaving the facility.

To protect residents' privacy and the facility staff, the QI paper will only provide contextual information about the long-term facility site. All written documents will omit the name and location of the long-term care facility, except for the forms required for submission to Montana State University and the Institutional Review Board (IRB).

Conclusion

Implementing a standardized aggression screening using the ABRAT-L assessment tool will likely improve resident care in a small rural Montana long-term care facility. There is consensus among stakeholders that a proactive approach to mental healthcare within the community can reduce crises. The Iowa Model was used as a general guideline for developing an implementation plan. The participation of nursing staff and the physician will be crucial to the project's success. As part of the data collection process, the project coordinator will informally check in with staff to determine their engagement and participation. The Iowa Model encourages teams to make changes when necessary to support long-term sustainability (Iowa

Model Collaborative, 2017). To achieve the five SMART goals, changes must be made during the implementation process.

The implementation of standardized aggression screening has several implications for residents of long-term facilities and rural communities. Violence can be prevented by treating residents' mental health before they reach a crisis state. When aggression is addressed early, physicians have more time to find appropriate resources and interventions for each resident. Data collection projects related to adverse resident outcomes can help advocate for more resources in rural areas. Implementing standardized screenings can improve outcomes for the American Indian population in the area, who are disproportionately affected by mental health disorders. By regularly discussing mental health during resident encounters, residents with undiagnosed mental disorders may be able to decrease stigma around mental health.

CHAPTER THREE

QUALITY IMPROVEMENT MANUSCRIPT

Contribution of Authors and Co-Authors

Manuscript in Chapter 3

Author: Emmaline Jackson

Contributions: analysis of the clinical problem, review of the literature, implementation

Methods, data analysis, first draft of manuscript

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Contributions: revisions, editorial review

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Manuscript Information

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Clinical Problem

Long-term care resident aggression is a growing public health issue that impacts their safety, health, and well-being. There are many physical health consequences associated with aggression, ranging from bruises to fatalities. There are also a variety of consequences including psychological distress, a lower quality of life, and a higher risk of hospitalization and premature death. Staff members may also feel stressed and unsafe if residents are aggressive towards each other and to staff (Botngård et al., 2020).

Approximately 7.6% of long-term care facility residents have demonstrated physical aggression toward staff members or other residents. The Ontario, Canada, Geriatric and Long-Term Care Review Committee (GLTCRC) identified 105 deaths worldwide, including 42 in the United States, because of resident-to-resident aggression (RRA) incidents occurring in long-term care facilities between 1988 and 2017 (DeBois & Chatfield, 2020).

Approaches targeting prevention may prove more efficient and practical than attempting to deal with the complications of crisis management especially in a rural setting where resources are limited. The aggressive behavior risk assessment tool for long-term care at-risk assessment tool can help healthcare providers detect aggression risk before a resident reaches a crisis state through standardized screening. As part of a quality improvement (QI) initiative, a rural Montana long-term care facility agreed to implement a protocol to standardize aggression screenings for residents.

Review of Literature

Patient violence in the healthcare setting is widespread (Lim et al., 2022). The literature has limited evidence to support brief screening tools for nurses to aid in identifying patients that maybe at risk for violent behavior, specifically, an easy to use and psychometrically reliable assessment tool to predict violent behaviors during admission is desirable (Kim et al., 2011).

Long-term care facilities failing to screen residents may miss aggressive behaviors, putting other residents and staff at risk. When staff do not screen for aggressive behavior risk, they cannot effectively manage aggressive residents or prevent aggressive behaviors proactively. Long-term care residents are particularly at risk for aggressive behaviors. According to Kim et al., (2019) approximately 1.4 million Americans reside in long-term care facilities and approximately half of them suffer from neurocognitive disorders increasing their risk for aggressive behaviors.

Based on the literature review, the ABRAT-L was found to be a suitable tool for identifying resident aggression in terms of sensitivity (ability to detect aggressive behavior) and specificity (ability to correctly identify non-aggressive individuals). Ongoing research supports the reliability and validity of the ABRAT-L and its predecessor the Aggressive Behavior Risk Assessment Tool (ABRAT) in different care environments and patient populations. Kim et al. (2011) reported high specificity (89.3%) and sensitivity (70.9%) when using the tool in medical-surgical units. Kim et al. (2022) found similar strengths in emergency department settings, with an even higher sensitivity (84.3%) and specificity (95.3%). Consistency across studies indicates the ABRAT can be a reliable tool for predicting aggressive behavior across high-stress hospital environments. For long-term care settings, Kim, Berry, and Young (2018) and Ravyts et al. (2018) focused on the ABRAT-L, which has a slightly lower sensitivity (56.6%) but retains high

specificity (90.8%). The researchers highlight the tool's capacity for early identification of aggression despite the different patient dynamics in long-term care (Ravyts et al., 2018). The tool's higher sensitivity in specific settings indicates its ability to accurately detect a greater number of potentially violent individuals in high-stress environments, which is crucial for staff and resident safety.

Conceptual Framework

The Iowa Model was the conceptual framework for the quality improvement project detailed below. The Iowa Model offers an easy-to-follow flowchart to help facilities improve outcomes through sustainable changes (Iowa Model Collaborative, 2017). With the Iowa Model framework, our team identified aggressive behaviors as a problem area for focus in the designated long term care facility. The next step led us to our purpose of implementing a standardized aggression screening within a long-term care setting. After forming a team and completing a review of literature, we then developed an implementation strategy to implement ABRAT-L screenings. The Iowa Model continued to guide the process through the pilot period, and adaptations were made to incorporate sustainable changes. The final step of the Iowa Model involved assessment and dissemination of progress toward the goals of the quality improvement project.

Aims and Purpose Statement

The overall goal of the quality improvement project included successfully implementing standardized ABRAT-L screenings with a protocol allowing for follow-up with a physician assessment. The project's short-term goal was to complete an ABRAT-L assessment on at least

85% of qualifying residents. Another goal was that a physician assessment be completed on at least 95% of resident's who screened positive on their ABRAT-L. Ideally, all residents with a positive ABRAT-L would receive a physician evaluation and necessary interventions. The ABRAT-L implementation is intended to reduce aggressive emergencies by providing early interventions.

Methods

Context

The small rural long-term care facility implementing the quality improvement project was located on an American Indian reservation in South-Eastern Montana. The long-term care facility was in a town with a population of 1,097 citizens. In 2022, there were 27.7 times more American Indian residents on the reservation than any other race or ethnicity (United States Census bureau, 2022). The most common employment sectors for those who reside on the reservation are healthcare, social assistance, public administration, and retail trade.

The long-term care facility's staff was comprised of one full-time physician and four full-time registered nurses (RNs). The physician treats all residents for routine, preventative care, and chronic conditions. If the residents have an acute illness, injury or medical emergency, they are sent to the emergency department next door at a critical access hospital for further evaluation. The long-term care facility is a 24-hour facility. The QI project focused on newly admitted residents.

Clinical observations and interviews with staff revealed frustration with the lack of resources available for residents experiencing aggression crises. The staff was interested in implementing a process assess for and prevent aggressive behaviors. At the time of

implementation, the staff administered ABRAT-L assessments to residents who were newly admitted to the long-term care facility. Otherwise, the long-term care facility had no standardized process for screening residents for aggression.

Practice Change

The nursing staff and management agreed to implement a standardized aggression screening tool by incorporating the ABRAT-L. An implementation team was developed and included myself as the project coordinator, two floor nurses and one physician. One nurse was designated as the primary point of contact between the project coordinator and staff. The team held an initial meeting and determined screenings would be focused on new admits with this at-risk assessment tool, known as the ABRAT-L. Exclusion criteria included newly admitted residents who refused to participate or if their power of attorney refused. The project implementation phase occurred over eight weeks starting on January 14th, 2025, and concluding on March 11, 2025.

Screening Eligibility. The implementation team focused on the newly admitted residents for the initial trial of standardized ABRAT-L screening within the long-term care facility. The ABRAT-L data was collected on newly admitted residents and any resident currently experiencing aggression symptoms during the eight-week implementation project. Residents were able to refuse screening at any stage of the process.

Route of Delivery. The ABRAT-L can be administered in several ways, such as verbally, electronically, or on paper. The long-term care facility did not have the ABRAT-L, or any aggression screenings embedded within the electronic health record (EHR). The staff felt most comfortable completing a printed copy of the ABRAT-L assessment during the nursing

assessment part of the admission process. Staff read the questions and answer based on the admission paperwork and resident history; if more information was needed, staff would call the family to obtain question answers on history of physical aggression.

The Process. Printed versions of the ABRAT-L were placed at the nurses' station and made easily accessible. To complete the ABRAT-L assessment, the nurse would conduct a resident history, and if the resident couldn't answer the questions on the ABRAT-L assessment, the nurse was advised to contact the family listed in their chart and ask them the questions on the ABRAT-L assessment if necessary. If the score was four or higher, a physician assessment was requested and completed on the resident. Completed ABRAT-L assessments were scanned into the residents' chart for future reference. Hard copies were placed in a secure filing cabinet in the director of nursing's office for review by the project coordinator at the end of the week.

An ABRAT-L score of less than four required no further intervention. A score of four or greater required a physician assessment. At this time, the physician would discuss the results of the ABRAT-L assessment with the nurse to make a clinical determination if the further interventions were required. This involved exchange of information between the physician and the nurse regarding the resident's condition, treatment plan, and if any other concerns needed to be addressed. If so, the physician would review intervention options, including a referral for a psychiatric evaluation, medication management, and a follow-up plan as appropriate based on the physician's assessment.

At the end of each week, the project coordinator collected the ABRAT-L assessments and compared the completed forms against the admitted residents. The ABRAT-L assessment were administered only to newly admitted residents during the admission process. During the planning

phase of this QI project, it was suggested existing residents would have the assessment administered to them during their quarterly assessments. A variety of quarterly assessments that include skin, nursing, dietary, activity, etc., are scheduled at different times for each resident. The long-term care facility has an assessment nurse to capture each resident's quarterly assessments when due. The quarterly assessments due within the QI project timeframe did not include the ABRAT-L assessment due to time constraints and only one staff member administering the assessment.

Positive ABRAT-L assessments required an audit to determine if the protocol was followed. The project coordinator ensured the ABRAT-L assessments were completed and the physician and nurse documented ordered interventions. The project coordinator made sure that the ABRAT-L screenings were placed in the designated folder at the nurses' station on a weekly basis to accurately evaluate outcomes. The designated folder was locked in a cabinet in the director of nursing's office at the end of each day. Every week, the project coordinator reviewed completed ABRAT-L screenings against newly admitted residents to ensure the protocol was followed. After completing the weekly audit, all ABRAT-L assessments were immediately destroyed. The data entered into the spreadsheet were deidentified, and no protected health information was collected or saved. A scanned copy of the ABRAT-L was entered into the resident's EHR. Additionally, the nurse would indicate whether the resident received a positive or negative ABRAT-L assessment in a nursing note. The note also included information on ordered interventions from the physician if the resident screened positive.

Communication and Follow-up. A week before the start date, the project coordinator met with the implementation team. An overview of the project's purpose was discussed, a flowsheet for

the screening process was discussed, a PowerPoint was used to introduce the ABRAT-L assessment and questions were answered. Feedback was accepted regarding the implementation plan. Staff were educated on the how to administer the ABRAT-L assessment to residents. Staff were provided with the project coordinator's phone number and email address so they could reach out to the coordinator between site visits. Data was collected weekly at the long-term care facility by the project coordinator. As part of this process, the project coordinator checked in with the charge nurse to see if there were any questions or concerns. Staff could express concerns or ask questions throughout the week during the informal check-in. During the sixth week of implementation, an official team meeting was held. As of this point, the project coordinator shared the data collected and preliminary observations discovered. During the first four weeks of the project, the team felt the administration of the ABRAT-L assessment was going well. Over the next three weeks, the project coordinator continued to check-in with the charge nurse on a weekly basis.

Measures

Data was collected weekly to monitor the progress of the implementation and assess trends in ABRAT-L responses. The project coordinator collected the ABRAT-L assessments and compared the residents screened to the admit schedule. Data collected for the spreadsheet at this stage included the number of total admits, number of residents eligible for ABRAT-L assessment, and number of screenings were completed. This allowed the coordinator to determine if eligible residents had not been screened.

ABRAT-L assessments were separated, and the positive results were counted. Following the positive ABRAT-L assessments, the coordinator completed a chart audit. During the audit,

the coordinator determined whether the residents were administered an ABRAT-L assessment, if the results were positive, and if the physician offered interventions or follow-up. During this stage, data was collected on how many ABRAT-L assessments were completed, how many positive ABRAT-L results were obtained, and how many physician interventions occurred. As a result, the project coordinator could track progress toward achievement of SMART Goals.

Analysis

A spreadsheet was used to analyze the data discussed above from a quantitative view. Based on the information collected, percentages were used to assess progress toward SMART Goals. The following categories were analyzed: residents eligible for ABRAT-L screening, ABRAT-L assessments completed, positive ABRAT-L results, and physician referral and assessments completion. Data was collected and percentages were calculated at four pre-determined dates during the project implementation.

By collecting data weekly, the coordinator was also able to evaluate progress toward SMART goals as well make adjustments to the protocol based on results. If missed screenings were identified, the coordinator interviewed staff to determine what situational factors contributed to the missed screenings. In addition, the nurse schedule was also reviewed to determine if scheduling constraints influenced project implementation during certain weeks.

Results

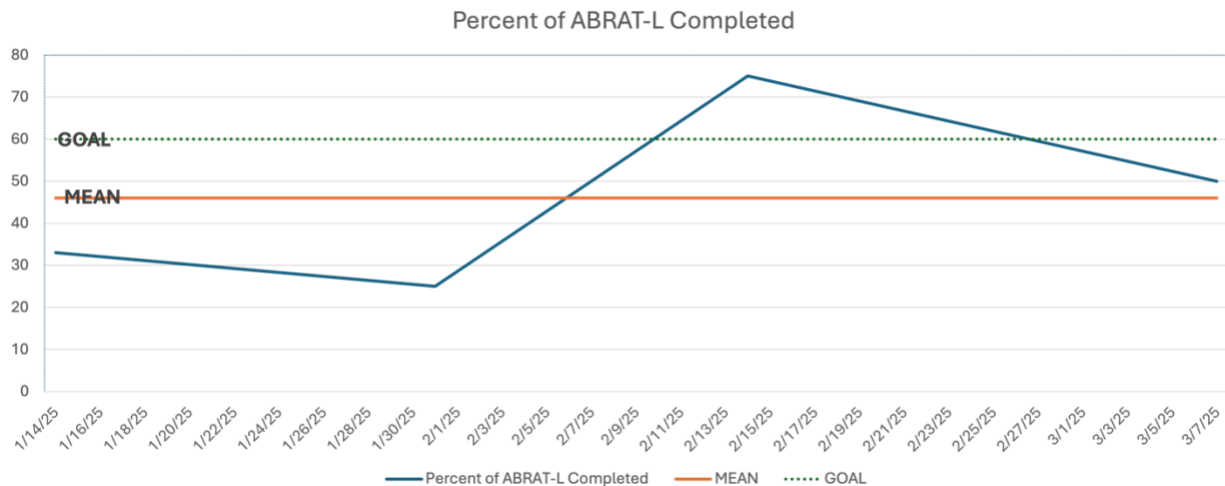
ABRAT-L Data

The project site had ten newly admitted residents that met the eligibility requirements for the ABRAT-L screening during the eight-week implementation period. Of the ten newly

admitted residents, the charge nurse screened ten (100%) of identified eligible newly admitted residents. There were 13 residents who could have been screened during their quarterly assessments; however screenings did not happen due to staffing/time constraints.

Of the ten residents who completed an ABRAT-L, four screened positive for aggression risk with a score of four or greater. A chart audit verified each resident with a positive ABRAT-L received an evaluation by the physician and what, if any, interventions the physician recommended. Interventions ranged from medication management, referral for psychiatric mental health evaluation, and planned follow-ups. Figure 3 (below) depicts the percentage rate of eligible residents who completed the ABRAT-L forms administered and collected by the nurse during each day of implementation.

Figure 3. Percent ABRAT-L Administered Run Chart



Discussion

The first short-term goal was for 85% of eligible residents to receive an ABRAT-L from nursing staff. Although only 75% of residents were screened during the eight weeks of

implementation, there was a shift during week four in the ABRAT-L administration percentage of completed assessments. Figure 3 visually represents the ABRAT-L administration median, which did not meet the goal of 85%. There were 13 residents who qualified for the ABRAT-L survey to be administered during their quarterly assessments. However, the assessments did not occur due to time constraints and only one staff member administering the assessment.

As previously mentioned, during the planning phase of this QI project the team decided current residents would have an ABRAT-L completed during their quarterly assessments. Unfortunately, the quarterly assessments due within the QI project timeframe did not include the ABRAT-L assessment due to time and staffing constraints.

The second short-term goal was to achieve a 95% all residents who score four or greater on their ABRAT-L assessment would be referred for physician assessment. Four newly admitted resident screened positive on their ABRAT-L assessment, all four residents (100%) were referred to the physician, thus the goal was met.

The third short-term goal was that the physician would assess and provide recommendations for interventions of an ABRAT-L score of four or greater. Upon audits of the ten screened residents, four of them screened positive and were referred to the physician for further evaluation. All four (100%) of the positive ABRAT-L scores of four or greater, received recommendation for interventions by the physician. All residents who were offered interventions received the recommended medications and went on to be scheduled for a psychiatric mental health evaluation.

Limitations

Several limitations were identified during the project. A significant limiting factor was the size of the resident population. The size and number of residents in the long-term care facility is small and as such there are few new admits. Because of this, the team suggested adding ABRAT-L to the current resident's quarterly assessments, however that did not happen. Another limitation involved nurse staffing shortages that corresponded with lower ABRAT-L administration rates. Week two had the lowest compliance with ABRAT-L administration at 25%. The final limitations to consider are self-reporting and observer bias. Cognitive impairment can make it difficult for residents to accurately report their own aggressive behaviors, and staff may be influenced by their own perceptions.

Recommendations

Future projects should include integration of the ABRAT-L assessment into the admission process. Integration of ABRAT-L documentation into the EHR would be ideal. If nursing staff can easily enter results during admission assessments, eliminating the paper form may improve staff adherence to screening processes. Additionally, direct entry into the EHR eliminates the need to scan documents and reduces the risk of misplacing paper questionnaires. Implementing a process for including the ABRAT-L assessment in this long-term facility can significantly enhance behavior tracking over time. By adding this assessment to quarterly assessments that are due it would provide consistent measures of aggression quarterly to monitor the resident's behavior. By incorporating a systematic aggression assessment such as the ABRAT-L into quarterly assessments in this long-term care facility, it would enable staff to monitor changes in aggression behavior over time, leading to improved individualized care, effective

intervention strategies, and ultimately, a better quality of life for residents. It fosters a responsive care environment by adapting to the evolving needs of residents.

Conclusion

The findings supported the inclusion of the ABRAT-L's into assessments to aid in identifying resident aggression risk within a long-term care setting. The short-term goals of the QI project were met with the exception of the completion of quarterly ABRAT-L assessments for existing residents. Over the eight-week period, four identified residents had their aggression risk assessed, and treatment recommendations offered, demonstrating the value of aggression screening in rural areas. Offering the ABRAT-L assessment improves the quality standards and allows early intervention for residents who may not otherwise receive treatment. Other rural long-term care facilities are likely to find the improvement project protocol helpful in developing routine screenings in their smaller facilities. In other rural long-term care facilities throughout Montana, the process could be easily duplicated and adapted to fit their unique needs. Further, the ABRAT-L assessment tool aims to enhance mental health care delivery and outcomes in a rural long-term care facility setting.

CHAPTER FOUR

ADVANCED NURSING ESSENTIALS REFLECTION

At Montana State University (MSU), the Mark and Robyn Jones College of Nursing (MRJCON) developed a curriculum modeled after "The Essentials: Core Competencies for Professional Nursing Education" by the American Association of Colleges of Nursing (AACN). The essentials are divided into ten domains, which are labeled as: Knowledge for Nursing Practice, Person-Centered Care, Population Health, Scholarship for Nursing Practice, Quality and Safety, Interprofessional Partnerships, Systems-Based Practice, Information and Healthcare Technologies, Professionalism, and Personal, Professional, and Leadership Development (American Association of Colleges of Nursing, 2021). My academic journey has included coursework in all ten domains over the past three and a half years, but a few stand out to me. As a doctoral nurse practitioner candidate, the following paragraphs will discuss the essentials that have guided my professional development.

Domain 1: Knowledge for Nursing Practice

The concept of knowledge for nursing practice is an adequate personification of what the nursing profession stands for and is deeply rooted in knowledge. Knowledge for nursing practice emphasizes the importance of evidence-based care. This foundation has encouraged me to critically evaluate research studies, understand their implications for clinical practice, and apply findings to improve patient outcomes. As a result, I have developed strong skills in analyzing and synthesizing research, which is essential for advanced nursing practice.

In our didactic courses (NRS 631, 632, 633, and 634) each remind us to look for a comprehensive understanding of multiple nursing theories and models, interdisciplinary collaboration that helps me understand the roles of other healthcare professionals and the importance of collaboration in patient care. This awareness has guided me in developing effective communication and teamwork skills, which are vital for providing holistic and comprehensive care. The domain of knowledge of nursing practice has taught me to grow my professional development by providing a strong theoretical and practical foundation, enhancing my clinical skills, and fostering interdisciplinary collaboration. These elements are essential for my growth as a doctoral nurse practitioner.

During the implementation of my scholarly project at the long-term care facility, I conducted a quality improvement project that examined the use of evidence-based protocols for detecting aggression in a long-term care facility. I researched the current literature, implemented best practices, and collaborated with the healthcare team to develop interventions that reduced aggression episodes, demonstrating my ability to integrate evidence-based practices into resident care.

Domain 2: Person-Centered Care

Person-centered care is a perfect example of nursing. Our undergraduate nursing education taught us to protect and advocate for patients. In the role of a provider, patient advocacy becomes increasingly significant and is a skill the nursing profession excels at. Throughout my graduate coursework, I have been reminded to treat people holistically, not just the disease. For example, I may diagnose two patients with major depressive disorder who are similar clinically. However, conversations and treatment plans differ based on each patient's

unique social considerations, perceptions, and priorities. One patient may be fearful of taking medications, while the other is more concerned about side effects from recommended medications. Both perspectives are valid and likely to influence how I approach individual treatment plans.

During my clinical rotations, I have had difficult conversations with patients. A clear understanding of the importance of empathetic communication quickly emerged. To ensure the patient feels cared for and in control of their health outcomes, it is important to facilitate conversations appropriately. It is important to support a patient's autonomy through shared decision-making, even when it does not match your recommendation, so the patient is able to ask questions and actively engage in their healthcare.

Domain 3: Population Health

Our NRS 614 course, Vulnerability and Health Care in Diverse Communities, offered the opportunity to explore the health care needs of diverse populations in our communities. As part of the course, we were also required to explore topics through books, documentaries, and podcasts. The multimedia approach of this course fostered an eagerness to learn, since I enjoy watching documentaries and listening to podcasts in my free time. During this course, I learned so much about how vulnerable communities are oppressed in the U.S. and what providers can do to alleviate these problems. As part of my patient care practice, I now examine myself for unintentional internalized biases.

I am from the Crow reservation and have cared for the American Indian population as a nurse nearly my entire nursing career. My participation in the class and learning about other tribes in Montana and the social/cultural barriers they face was informative. I found that common

trends correlated with poor mental health outcomes were directly related to accessibility. Reservations mostly rely on Indian Health Services, which offers a limited number of appointments to meet a limited amount of mental health needs. Several adverse mental health outcomes, including suicide rates, are heavily influenced by access to mental health services. There were also accessibility issues related to transportation and distrust within the medical community that were discovered. Through this rotation, I gained valuable insight into how I can provide better care to the American Indian population. I can use my knowledge as a psychiatric mental health nurse practitioner to provide culturally competent care. Understanding cultural beliefs about health, healing and wellness can enhance a patient's trust and compliance.

Domain 4: Scholarship for Nursing Practice

Throughout my doctoral program, I spent many hours learning how to analyze and explain scholarly information and research. Both Evidence-Based Practice I and II (NRSG 604 and 605) and Statistical Applications (NRST 606) explored the development and use of guidelines. It is common for research publications to be published; clinical and statistical significance may not always be proven. As doctoral prepared nurse practitioners, we need to determine the validity of the research presented. We must dissect information and evaluate the sources.

I found that providing relevant evidence during patient visits was beneficial. Patients who are misinformed about medications like antipsychotics or antidepressants could benefit from this technique. Explaining to patients why these medications may or may not be appropriate using evidence-based/research-based approaches can impact the outcome of the care they receive. Choosing the right words and using the right tone are vital to avoid minimizing or dismissal. I

received some great examples of how to approach these discussions in my psychopharmacology courses.

My scholarly project focuses on resident aggression in a long-term care facility located on a rural Montana reservation that primarily serves indigenous populations. This topic was chosen based on a thorough review of the needs of the long-term care center, and a review of literature, which highlighted significant health disparity. In April 2025, my scholarly project will be presented at the nursing research conference of the Western Institute of Nursing. By sharing my research with other professionals, engaging in dialogue, and receiving feedback, I can refine my work further. My dissemination plan includes a multifaceted approach, targeting academic audiences, community members, and stakeholders. It is imperative that these findings have a broad and meaningful impact on addressing mental health issues in long-term care facilities. Through these efforts, I hope to contribute to the ongoing conversation about Indigenous health. I also want to promote effective, culturally competent interventions that lead to sustainable improvements.

Domain 5: Quality and Safety

The final year of the doctoral program involves the development, implementation, and defense of a quality improvement project. By doing so, students can put into practice their knowledge gained throughout the program that will improve workflow, patient safety, and overall outcomes. I have gained an appreciation for the process and what it stands for after discovering just how much time and effort goes into developing practice guidelines, policies, and safety standards. While implementing my project, I learned how ideas must evolve and be adapted in a healthcare setting.

My scholarly project was based on implementing an aggression assessment to newly admitted residents at a long-term care facility in hopes of reducing aggression crisis's. By continually evaluating outcomes, gathering feedback, and being open to change, we can evolve this strategy to better meet resident needs and improve overall care quality. This iterative process not only enhances resident outcomes but also fosters culture continuous improvement within the long-term care facility.

The process was challenging, but reflecting on the progress and impact of the project is rewarding. With this knowledge, I am more confident in my ability to lead change as a nurse practitioner. After completing my scholarly project, I have a framework that I can use to make measurable changes in my future practice environment.

Domain 7: Systems-Based Practice

The task of providing high-quality care in an inefficient and complicated healthcare system is one of the most challenging aspects of advanced practice. Nurse practitioners provide care to patients of all backgrounds; however, healthcare access is not equally accessible to all. During my coursework, many of my professors discuss financial responsibility in healthcare. To determine a clear diagnosis, several diagnostic tests may be ordered, but this is not always necessary. It is sometimes necessary to perform comprehensive testing; however, charging a large medical bill to a patient can be detrimental. Each time I order a test; I think about my goals. During my clinicals, I have seen a few providers order unnecessary labs that the patient could have done without. However, I have also learned how the results will impact my care provided.

I have talked with many patients about alternative treatments due to their inability to afford what is typically recommended. It has been my observation that many patients prefer

natural/herbal treatments in mental healthcare. This works for some patients with inadequate health insurance coverage. However, there are many patients who lack adequate insurance coverage and cannot manage the healthcare expenses they wish to receive. By having the skill set to advocate for my patients, my goal is to improve their access to healthcare. A few examples include helping patients apply for Medicaid, providing resources to help them pay for their medications, or completing peer-to-peer reviews with their insurance company to approve non-formulary treatments.

Conclusion

My professors and clinical preceptors have prepared me to begin the next chapter of my professional journey as a nurse. I am forever thankful. Having gained knowledge over the last four years, I feel confident in my ability to apply the AACN's nursing essentials to the care I provide as a nurse practitioner. Montana State University's MRJCON has thoroughly addressed all ten domains of the nursing education essentials. As an advanced practice provider, these domains have helped define my ethical and moral responsibilities. As I conclude my graduate school journey, I am proud of what I have accomplished and look forward to learning more throughout my career.

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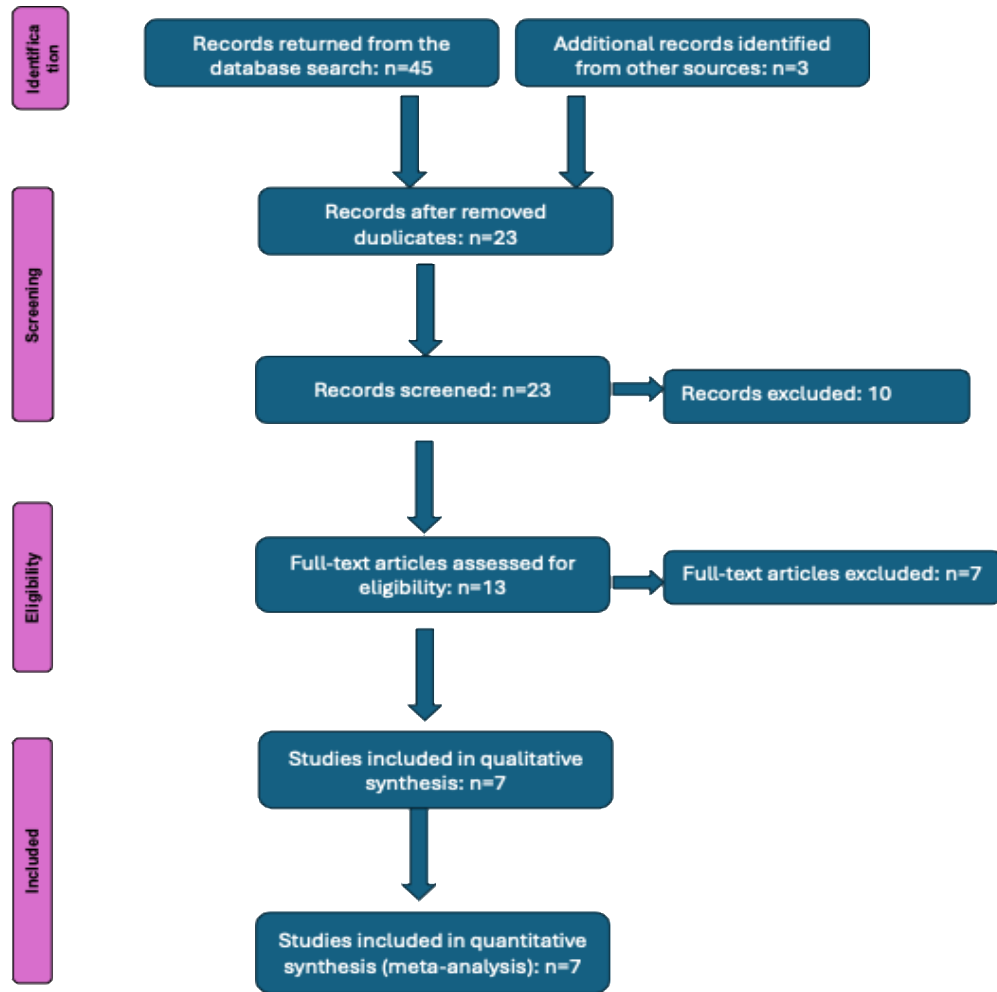
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APPENDICES

APPENDIX A

PRISMA DIAGRAM

Figure 4. PRISMA DIAGRAM



APPENDIX B

PERMISSION FOR IOWA MODEL

Figure 5. PERMISSION FOR IOWA MODEL

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