Mission Health’s Journey to Prevent Workplace Violence

Hospitals Against Violence: Addressing Workplace & Community Violence to Support the Workforce
Friday, July 28, 2017

Please note that the views expressed are those of the conference speakers and do not necessarily reflect the views of the American Hospital Association and Health Forum.
Mission Health at a Glance

Tracing its roots back nearly 120 years and based in Asheville, Mission Health is western North Carolina’s only not-for-profit, independent community healthcare system. Mission Health, through its vision to provide world class care to western North Carolina and beyond, is the tertiary care regional referral center for the western part of the state and the adjoining region.

Employing nearly 11,000 dedicated professionals, the system includes seven hospitals with some 1,145 licensed beds; some 400 employed medical providers; and more than 1,200 total physicians on its medical staff.

Mission Health is dedicated to improving the health and wellness of the people of western North Carolina. For more information, please visit mission-health.org.
Western North Carolina 18-County Service Area

Population (2016): 882,581
Percent over 65: 22%
Over 90 ambulatory clinics (primary and specialty)

Our BIG(GER) Aim

To get every person to their desired outcome, first without harm, also without waste and always with an exceptional experience for each person, family and team member.
Why Focus on Physical Assault Reduction?

- Behavioral Health patients overflow to medical beds
- Topic of assessment from Sentinel Events and Patient Safety Events
  - Identified as causal factors in various Root Cause Analyses
- No identified way to track and trend assaults
- No established industry standard on assault reduction
- Assaults identified in top 5 Employee Safety Concerns (slide 28 for more detail)
Physical Assault Reduction

Multi-disciplinary Assault Reduction Team
- Nursing
- Psychiatry / Mental Health Clinicians
- Security
- Quality / Performance Improvement
- Risk Management
- Informatics
- Education

Monthly Review of Data
- Assaults
- Preventative measures
- Improvement opportunities
- Strategies

Tailor Approach by 4 General Segments
- Medical Surgical
- Emergency Department
- Psychiatric Units
- Regional Hospitals
Med-Surg: Problem and Goal

Safety of patients, staff and providers is compromised due to:

• Behavioral challenges presented by patients in non-Behavioral Health care areas (agitation, withdrawal, dementia, other psychiatric complications)
• Limited resources to prevent and manage disruptive behavior
• Lack of coordinated process to respond to events

Goal: Enhance safety of patients, staff and providers by creating:

• A rapid response service to assist caregivers in deescalating behaviors that threaten the safety of the environment in Med-Surg areas: Behavioral Emergency Response Team (BERT), leveraging expertise in response to medical emergencies.
BERT: Guiding Principles

- 24/7 availability
- One call
- Immediate response
- Multi-disciplinary team of responders with Behavioral Health and de-escalation expertise
- Continuous development based on feedback/outcome data
Response Process

Pt behavior escalates → Deescalation attempts by floor staff → Pt behavior continues or escalates

Code BERT activated by calling hospital operator; team paged overhead

Team arrives to floor within 15 minutes (security sooner)

Verbal de-escalation led by BH clinician

Medications obtain/administered by primary nurse (as needed)

Team debrief

House supervisors continue to round on patient daily
# Nursing Survey

First Year of Behavioral Emergency Response Team

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• 285 Responses from Nursing Staff, **70% of whom** had participated in a BERT call

• Future assessments incorporated into NDNQI reporting
ED Behavioral Health Intakes Per Day
Assault Prevention: An Ongoing Learning Process

- BERT team support improves staff comfort with behavioral health patients
- Some long stay patients with high risk for assault need more robust behavior management plan
- Need treatment recommendations to follow patients at high risk for assault on subsequent visits (Behavioral Threat process in place)
- Training in trauma informed care for units with concentrations of patients with behavior problems
- System Assault support process for staff when assaults occur
- Some assaults severe enough to warrant CISM for the unit involved
- Monthly review of assaults with tweaking of system approaches to avoid entropy and complacency
- Assault-related medical costs 2013-2017: Total events are up, Total cost per year flat, Average Cost per assault down.
## Assault Reduction Improvement Efforts

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What We Know and Do Not Know

We know:
- Staff appreciate all of the efforts to reduce assaults, and feel safer in their jobs
- Intervening at early stages of escalation is generally helpful and effective
- Communication among all disciplines is critical
- Having clarity in roles (Nursing, Security, Physician, BH) is integral to success
- Having meds readily available (agitation protocol) is important, although not always necessary

We do not know:
- If we are experiencing an increased sensitivity to assaults (increased reporting)
- Our historical data on severity of assaults (in process of changing with better reporting system)
- Impact of community factors on assault behavior (i.e. drug abuse impact)
- Are we better, worse, or comparable to other integrated systems, given the lack of any national risk-adjusted benchmarking for assaults in hospitals?
Conclusions

• Managing workplace violence in healthcare requires board-level support and a multidisciplinary data-driven approach

• National benchmarks / opportunities to develop and share best practices among health systems are lacking

• There is a burning platform for a national effort to define, measure, intervene upon, and reduce assaults in healthcare

• Focus on resiliency education and support
In Closing

• Share Mission’s experience around workplace violence

• Learn what other providers are doing to improve team member safety

• Seek opportunities to collaborate with the AHA and other health systems to benchmark and share best practices
Appendix
BERT Calls
Cause/Effect Analysis (Fishbone Diagram)

Environment
- Inconsistent milieu
- Physical proximity to pt
  - Triggers: phone, meal time, visiting
- Access to objects (walker, coffee)
  - Shift Change
  - Pts visible?
- Within 5 days
- Dementia/Delirium
- Staff moving bed
- Male, 18-40
- Thursdays
- Asst with ADLs
- Restrictions: Seclusion, Therapeutic hold

Staffing
- RN leaving unit for meds
- Under Staffed
- IDD
- Hx violence
- Baseline
- Prodrome
- Agitation

Clinical

Physical Assault to Staff

Other

Communication
- Issues with limit setting
- Info sharing

Med Management
- Meds not in Pyxis
- PRNs not ordered
- PRNs not given
- Substance Abuse Pt demanding meds

Baseline

Triggers

Recognize Escalation

Intervene

VS (9/03/15)
Management of High-Risk Behavioral Health Patients

Patient at-risk

Assessment with ABRAT

Behavior management plan

Pt escalates

Nursing staff/provider de-escalation efforts

Continued escalation/safety risk

Intervention preparation

Analysis

System assessment & learning

Maintenance

De-escalation

System response. BERT

Resiliency training.

Ongoing support/ CareTyme

Initial Support/ RLS Input/CISM

Assault/ Injury

Nurse Mgmt, Nurse Ed, Consult Clinician, Psychiatrist

Green = Active
Blue = Planned
Orange = Pilot
### Critical Success Factors | Challenges
---|---
Organization was "ready" | Disparate data sources
Senior and mid-level leadership support | Benchmarking limitations
Multi-disciplinary, engaged oversight team (Nursing, Security, Behavioral Health, Informatics, Risk, Perf Improvement) | Consistent de-briefing
Ongoing monitoring and tweaking | Rolling out to smaller facilities
Focus on early intervention |  
Staff encouraged to call without hesitation |  
Talented, engaged and compassionate responders |  
Implemented largely "on the margins", modest financial investment |  
Medication "Agitation Protocol" |  
Active psychiatric consult service in medical areas |  
Staff surveys, ongoing modifications |  

Pt behavior escalates

Deescalation attempts by floor staff

Pt behavior continues or escalates

Code BERT activated by calling hospital operator; teampaged overhead

Pre-BERT Call

Team arrives to floor within 15 minutes (security sooner)

Verbal de-escalation led by BH clinician. Evaluate needs

De-escalation unsuccessful

Or

Communicate with patient/family

Medications obtain/administered by primary nurse (as needed)

Restraints if necessary

Developed standardized debrief tool for team and to help with data collection

Resolve & Team debrief

Developed agitation management power plan within EMR; ensure meds in plan are stocked in strategic locations

House supervisors continue to round on patient daily

Ongoing education with deescalation techniques; ongoing CPI certification
Assault on staff occurs

- **Physical Assault/Threat**
  - Sup/NUS/Charge Nurse notified
  - Sup/H5/NUS debriefs employee & evaluates level of injury/distress
  - Sup/H5/NUS and victim complete RLS together to ensure all details are complete, and as a debrief
  - Workers Comp notified (RLS transfers info to Risk Master)
  - Review ED/OccuMed records
  - Utilize EAN protocol as indicated
  - Manage claim
  - Workmen’s Comp contacts employee next business day (if off of work)

- **Emotional/Verbal Assault/Threat**
  - House Sup/AOC/Manager notified
  - Employee accompanied to Staff Health and/or ED/CISM
  - Sup/H5/NUS completes RLS with employee
  - EAN referral always offered, mandated if appropriate

- **Staff Health & CISM**
  - Sup/HS/NUS contacts lead or on-call CISM / CISM assessment begins.
  - Sup/HS/NUS completes RLS with employee
  - EAN referral always offered, mandated if appropriate
  - Note: Weighing patient safety and employee support and safety

- **ED/OccuMed**
  - CISM and Manager follow-up at 2-3 days with employee, manager if appropriate.
  - CISM and Manager follows up with employee in two weeks

- **House Sup**
  - House Sup approves Supportive Administrative Leave for shift.
  - Manager communicates with unit staff with CISM input, determines additional needs.

- **Actor**
  - Call 213-0511/Security as appropriate
  - Note: Methods of follow up including location to be determined

- **Workers Comp**
  - Notified
  - Contacts employee next business day (if off of work)
  - Manage claim
  - Review ED/OccuMed records
  - Utilize EAN protocol as indicated

- **Note**
  - Additional time, up to 3 days, with daily review by manager, may be allowed.
  - Mandated EAN referrals must be made on performance issues
Behavioral Health Patients Boarding
Mission Hospital
Mission Health Psychiatric Boarding
Board Engagement in Team Member Safety
CY2016 Year to Date Top 5 Employee Safety Categories

- Sprain/Strain/Fracture: 24%
- Fall/Slip/Trip: 41%
- Assault: Highlighted
- Laceration / Abrasion / Contusion: 53%
- Sharps Injury: 65%
- All else (Each 2% or less): 73%
- All other (Each 2% or less): 100%

Legend:
- Blue: Percentage of All Event Types
- Green: Cumulative Percentage
Assaults: Mission Hospital Emergency Department

High-volume Emergency Department with very high volumes of Behavioral Health Patients. Assaults appeared unpredictable and violent.

Interventions

• Early recognition of escalating behavior, use of Crisis Prevention and Intervention (CPI) and medications as needed
• Consistency in providing daily medications
• Reduce patient-team conflicts through focus on empowerment versus “limit setting”
• Immediate availability of Security as indicated
• Consistent availability of BH-specialized staffing in designated BH area
Mission Hospital Emergency Dept Assaults
Assaults: Psychiatric Units

• Assaults have increased for Mission’s psychiatric units (and associated holding areas) over the past year.
  – *Contributing factors include increased acuity increased boarding of unstable patients*

• Data suggested BERT may be more effective in reducing assaults
• BERT-like model recently adopted by the psychiatric units
Psychiatric Unit Assaults
Assaults: Regional Hospitals and Ambulatory Entities

- Assaults infrequent but more difficult to manage given more limited staff

- Intervention: Improve tools available to staff
  - CPI training for all staff
  - Implementation of system wide safety precautions policy

- Result: Assaults are falling despite increased psychiatric boarding

- Initiating regional implementation of BERT team concept summer 2017
Assaults: Regional Hospitals and Ambulatory Entities