Addressing Violence Through Behavioral Health/Behavioral Safety Teams

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Cincinnati Children’s

- Established 1883
- Academic
- #3 pediatric hospital by U.S. News & World Report
- Magnet designated
- 678 inpatient beds and 30 residential psychiatry beds
- 12 off-site locations
- Emergency, urgent care and home care services
- Patients from 50 states, 68 countries
Objectives

• Review methods and framework for “Employee Safety” journey
  – Improvement Science Principles
  – Reliability Principles

• Review interventions and clinical concepts
  – Risk Identification
  – Behavioral Personal Protective Equipment
  – Skilled Behavioral Health Employees
IHI’s Model of Applying Reliability Principles

A. Prevent Failure (a breakdown in operations or functions)

B. Identify and Mitigate Failure (intercede before harm is caused, or mitigate the harm caused by failures that are not detected and intercepted)

C. Redesign the process (based on the critical failures identified)

Key Improvement Science Principles

a. Key Driver Diagrams
b. Run charts/Control charts
c. Plan, Do, Study, Act
d. Reliability principles

Improvement Methodology

• Intermediate Improvement Science Series (I2S2) (The James M. Anderson Center for Health Systems Excellence, 2011), guided the quality improvement methodology
• Formal quality improvement began May 2011
• Frontline staff were engaged in the initiative and Specialty Resource Unit who provided staff to all units were key stakeholders for interventions and testing
• Plan-Do-Study-Act (PDSA) methodology utilized to learn and guide intervention development
• Weekly run charts with raw data measuring all staff injuries were utilized to guide initiatives and measure outcomes.
• Run charts were annotated to reflect interventions tested and adopted across chronological timeline of the initiative.
Define

Problem Statement:
Children and adolescents with behavioral, developmental, and psychiatric disorders in need of medical care often present with severe aggressive behaviors which place staff at increased risk of injury when admitted to medical/surgical inpatient units. The frequency and severity of injuries to staff due to patient-related interactions were a concern to clinical staff and leaders.

Project Aim:
• To utilize quality improvement principles and interventions to reduce staff injuries on medical-surgical inpatient units.
• Reduce the number patient interaction related staff injuries by 50%.
• Increase the days between OSHA recordable injuries to 200+

Interdisciplinary Team:
Psychiatrist, Psychiatric Nursing Clinical Director, Behavior Psychologist, Medical Nursing Directors, Unit Nurses, and Occupational Health & Safety
**Project Name:** Hospital Behavioral Safety  
**Project Leaders:** Rena Sorensen, Mike Sorter & Adam Hill

**Revision Date:** 10/03/2014

**SMART AIM**

**#1** Decrease staff injuries, related to aggressive patient interactions from 2.5 per week to 1 injury or less for all patient areas, excluding Psychiatry by June 30, 2015.

**#2** Maintain OSHA recordable staff injuries, related to aggressive patient interaction at 0 for all patient areas excluding Psychiatry.

**GLOBAL AIM**

Assure the safest, highest quality care for patients presenting behavioral safety challenges.

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**KEY DRIVER DIAGRAM**

**KEY DRIVERS**

- Reliable identification of aggressive patients
- Reliable and easy system to access communication of patients at behavioral risk
- Situational Awareness
- Standardized Key (Critical) Processes
- Care Coordination
- Create a safe environment
- Study failures*
- Care Delivery
- Staff Education

**INTERVENTIONS (LOR)**

- Admit Nurse completes Behavioral Risk Screen (in EPIC/Admission Navigator) (LOR 2)
- EPIC ‘flag’ for behavioral safety: soft stop security risk in EPIC (LOR 2)
- EPIC Documentation (LOR 2)
  - PPOC Goal
  - Behavioral Intervention Plan
  - OAS Shift Documentation
  - Visual System (Door Signs)
- Ability to link the Behavior Plan to and print from the FYI tab in EPIC (LOR 1)
- Situational Awareness (LOR 2)
  - Patients identified (SA) as employee safety risk
  - Hospital Bed Huddle
  - Rounding on Staffing Patient
  - Best Huddle
  - Selection and Use of PPE
- Bst Process Map (LOR 2)
- Standardized process of how staff are assigned to Best patients (LOR 2)
  - Selection and Use of PPE
  - MHS Backpack (standardized content) (LOR 2)
  - Identified Best Care Team (LOR 2)
- Understand differences in Ambulatory Services vs. current Inpatient System
- Standard Risk Assessment and Strategies for Adapting Environment of Care (LOR 2)
- Standardized process for identifying Re-admitted (frequent flyers) high Risk Best Patients
- Debriefing of incidents (LOR 2)
  - SRU Team
  - Unit (RN/MD/MHS) Development of severity rating for employee injuries
  - Learning Plan for OSHA Recordable events
- Timely Transfer of Best Patients to Psychiatry (LOR1)
- Staff education/training- global (LOR1)
  - Nurse and PCA Blitz
  - New Employee Orientation
  - Code Violet Process
- Patient binder bundle (on the Unit) (LOR1)
- Crisis Prevention & Intervention (CPI) training for affected staff (LOR 1)
- Multi Disciplinary Coordinated schedules and supports (LOR1)

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*Failure
Any behavioral incident results in injury or harm to another person.

Aggressive Patient
Any incident, attempt or inadvertent behavior that can result in injury or harm to another person.

OSHA Recordable Injury
An injury resulting in loss of work time, work restrictions or treatment greater than first aid.
Adopted Interventions:

Timely Identification of At-Risk Patients

Every inpatient is screened at admission using the “Behavioral Risk Screen”

Visible Communication of Risk

Banner and behavior plan in the patient medical record clues staff in to safety risk

Skilled Staff at Bedside

Increased training plus new Mental Health Specialists roles added to medical center by converting PCA FTE’s

Behavioral Consultation Team

Psychologist, Behavior Specialist and Child Life Specialist consult on each patient

Personal Protective Equipment (PPE)

PPE is available hospital-wide and patients are evaluated to determine appropriate PPE for staff
## Personal Protective Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hat</td>
<td>hair pulling</td>
</tr>
<tr>
<td>Arm Guards/Pads</td>
<td>hand/fist-to-head hitting, scratching, pinching, biting, pushing, grabbing</td>
</tr>
<tr>
<td>Kevlar Sleeves</td>
<td>scratching, pinching, biting, grabbing</td>
</tr>
<tr>
<td>Kevlar Gloves</td>
<td>scratching, pinching, biting, grabbing</td>
</tr>
</tbody>
</table>
Adopted Interventions (con’t)

• “Employee Risk” review as a standard part of hospital nursing bed huddles
  – Prediction, Identification, Mitigation
• Critical review of employee injuries as a result of patient aggression
  – Standard content for cause analysis
• Establishing centralized methods to identify and manage:
  – Patient identified as potential aggression risk
  – Employees with behavioral health expertise
Employee Safety/Aggression Management System Design (January 2017)

1) Risk Identification & Stratification
2) Centralization of all “employee safety risk” patients
   a) “Real time” information for informed operational decisions
   b) Historical aggregated data to better understand demand

Operational Management
1. Who/How/When Patient Assign/Match Made
2. Mitigation of “Gaps” & Escalation Process

Centralized Patient Risk List
- Stratification of Aggression
  - High
  - Low

Employee Resource
- Aggression Management Skill Level
  - High (Expert)
  - Medium (Proficient)
  - Level 1 (Competent)

1) Foundational - Training & Education
   a) New Hire
   b) Ongoing
2) Skill “Leveling”
3) Centralization - “Real Time” Snapshot of resource availability
Employee Wellbeing

• Emotional Support Team
  – Hospital Wide Team
    • Employee Health, Pastoral Care, Social Work

• Event Support
  – Group Support
    • Pause – Within few hours
    • “Code Lavender/Compassion” – with 24 hours
    • Debriefing – Within 5 days
  – Individual Support
    • Employee Assistance Program
References:


