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Mitigating workplace violence: An interdisciplinary approach to a behavioral response team

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Patient-initiated workplace violence is a daunting reality and poses a constant threat of physical and psychological harm to hospital employees. These violent events significantly impact nurses in our healthcare institutions. Healthcare workers accounted for 73% of all nonfatal workplace injuries and illnesses due to violence in 2018 (see *Figure 1*).[1] Mitigating this workplace violence has become a major challenge that requires immediate attention and urgent interventions.

Tuominen and colleagues in an integrative review found that workplace violence is negatively connected to staff's psychological, emotional, and physical well-being at work, and work performance. The review also found that leaders were challenged by workplace violence without training or support from employers, and employees were disappointed with their leaders and desired to make the environment safer.[2] High-tech and high-touch interventions are suggested to promote safe environments for healthcare workers.[3] Workplace violence mitigation aids in repairing the cracks in the foundation of the care environment that can undermine nurse resiliency.

Background

In an urban academic medical center, the institution's Experience Department and Respect Office collaboratively developed a Respect Credo using the core value of respect as a foundation for interacting with patients and each other. Even with this credo in place, nursing on the medical service line identified a need to expand interventions related to the institution's culture of safety for employees. Prior to the pandemic, the institution introduced Zero

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Harm initiatives, including de-escalation training, immediate security notification methods, assignment of a Psychiatry liaison, the addition of mental health workers to a medicine unit, and a Zero Harm WorkSafe portal to report incidents of physical and verbal employee harm.

Focusing on staff safety, the institution, administrators, and nursing leadership identified further areas for improvement to protect staff members and reduce the fear of harm related to workplace violence. Additional hospital-wide initiatives in 2021 included nursing assessment and electronic health record (EHR) flagging of patients at high risk for violence, and signage listing nonacceptable behaviors for visitors and patients. In 2022, nurses on four medical inpatient units noted an increase in the incidents of physical harassment and physical assaults. On one medicine floor, there were 17 physical assault incidents reported through the WorkSafe reporting system in the span of just a few months.

Staff brought up the issue in nursing forums and professional governance committees. This increase in workplace violence and employee harm was the impetus for immediate actions. Initial interventions included utilizing security detail rounding on the medical floors and installing panic buttons on the medical units.

Hospital leaders have an opportunity to address violence and workplace safety threats.[4] This article describes how a collaborative, interdisciplinary leadership team within the hospital designed and implemented a Behavioral Emergency Response Team (BERT) to continue efforts toward the goal of zero employee and patient harm, and its impact, utilization, and successes. Nurse leaders took part in the process and were integral members of this collaborative team.

Project aims

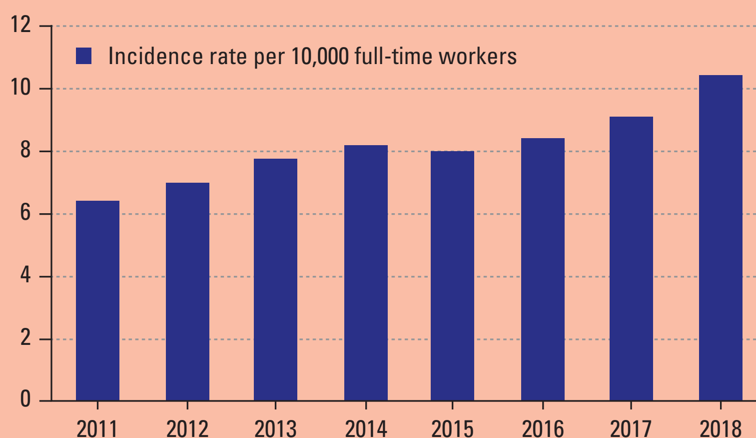
The purpose of the BERT initiative was to reduce workplace violence, increase the feeling of staff safety in the workplace, decrease staff fear due to disruptive/violent patients, and boost staff confidence and perception of support from management during behavioral emergencies. The BERT initiative was planned to provide urgent access to a rapid response team and treatment recommendations for emergent issues. The interdisciplinary BERT leadership team was encouraged by the literature indicating that BERTs are effective at reducing assaults directed at staff and are associated with increased staff satisfaction.[5]

Methods

Psychiatry assembled a core team of hospital leadership personnel to coordinate a BERT program. The interdisciplinary collaborative team, which included representatives from the Nursing, Psychiatry, Security, and Patient Services Administration departments, met once a month to discuss and formulate the goals, methodology, specific interventions, education, and policy development of the BERT. The vision was to form a team of interdisciplinary specialists who could rapidly respond to events involving inpatient behavioral emergency situations and aid with recommendations and interventions. This immediate response and intervention would supply resources and support and potentially prevent and reduce the impact of workplace violence and harm. The BERT was to be designed for all 33 inpatient units at the pilot campus.

Nurse adminstrators created a pre-BERT survey that was approved by the CNO. The nurse administrators and patient care directors distributed the survey to RNs on the inpatient units. (see *Figure 2*). Participants were

Figure 1: Healthcare worker incidence rate of nonfatal workplace violence, 2011-2018



Source: U.S. Bureau of Labor Statistics

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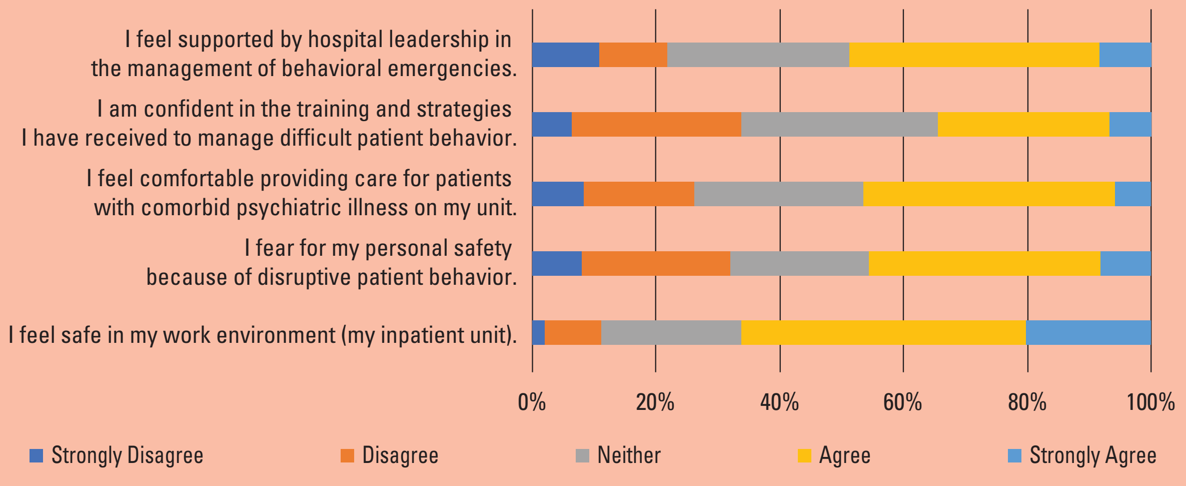

informed about the purpose of the survey and that their answers would be anonymous. There was no incentive offered to participate.

The following five statements were rated on a Likert-type scale from strongly agree to strongly disagree:
1) I feel supported by hospital leadership in the management of behavioral emergencies.
2) I am confident in the training and strategies I have received to manage difficult patient behavior.
3) I feel comfortable providing care for patients with comorbid psychiatric illness on my unit.
4) I fear for my personal safety because of disruptive patient behavior.
5) I feel safe in my work environment (my inpatient unit).

A total of 115 RNs responded to the pre-BERT survey. Results revealed that more than 45% of those surveyed feared for their personal safety because of disruptive patient behavior, and fewer than 35% felt confident in the training and strategies received to manage violent/disruptive patient behaviors.

The BERT pilot required a clear blueprint of strategies and methodologies, establishing a proactive process for immediate response to assess and evaluate a patient exhibiting an acute mental health issue or a patient who poses a potential threat to themselves or others. The BERT response team includes members from Psychiatry (resident, attending, fellow, or NP); Nursing (primary nursing team, clinical nurse manager, patient-care director, or nurse administrator); Security; a mental health worker, if available; and Patient Services Administration or the administrator on call, depending on the time of day. When possible, the primary team is notified for initial assessment and intervention prior to calling the BERT; although the calls may be simultaneous, as an element of the collaborative nature of the program.

Education

Before the BERT rollout, the education department, in collaboration with the core BERT committee, developed informational videos for BERT responders, inpatient providers, and staff. All employees were encouraged to view the applicable videos on the institution's learning center prior to the BERT launch. The videos provided details about the BERT process and how it benefits the patients, staff, and providers.

The chief operating officer, vice president of Psychiatry, CNO, and vice president of Security and Emergency Management sent a hospital-wide email to alert staff about the BERT pilot and start date along with a brief program description and a reminder to complete the educational learning modules. To activate a BERT, an easy-to-remember phone number was created, which could be called from any hospital telephone. Nursing administrators also created an informational flyer and posted it on each inpatient unit to reinforce the BERT goals, process, and activation telephone number. There were scheduled simulation classes for all members of the BERT response team, which proved to be an invaluable

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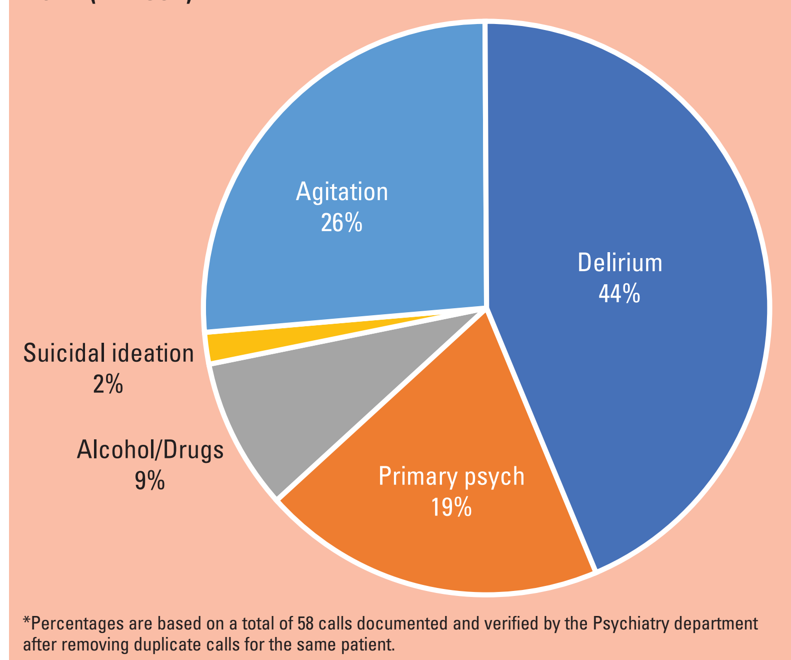
experience. Additionally, learning opportunities during the BERT activations, and the education of nonbehavioral health personnel about psychiatric interventions such as de-escalation and crisis prevention, were found to be very helpful. This new knowledge that clinical RNs acquired built confidence in modeling behaviors for addressing similar future interactions.

BERT process

Before calling the BERT for a patient exhibiting violent, aggressive, or inappropriate behavior, the primary team should evaluate the patient and determine interventions. If the patient continues to escalate, the BERT is called by using the designated phone number to contact the operators and provide them with the patient's unit and room number. The operator then alerts the BERT response team via Rover, a mobile app on the hospital smartphones that interfaces with the Epic EHR, by broadcasting a notification to all team members in a BERT role. All team members must log in at the beginning of the shift to the BERT role to receive alerts.

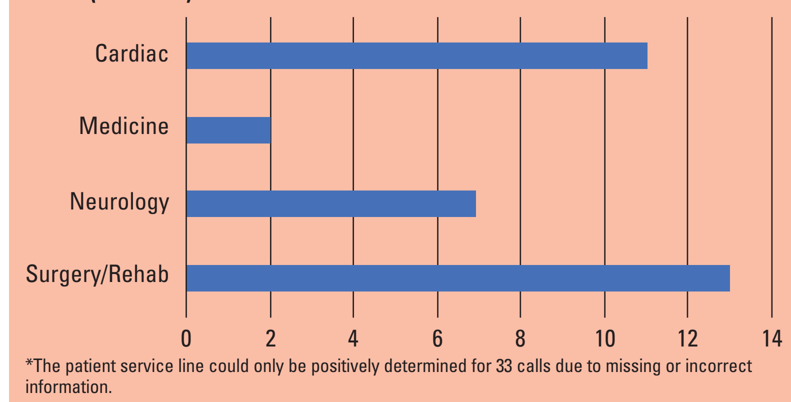
Once the BERT arrives, the Psychiatry team member receives a brief report from the primary RN and provider team. The Psychiatry team member then completes de-escalation techniques and a patient assessment with recommendations for interventions and medication. After the patient's behavior has appropriately been de-escalated and controlled, Psychiatry leads a debrief with the BERT team, the primary RN, and the primary team, and places a post-BERT note in the EHR.

Figure 3: Reasons for BERT activations, August-December 2022 (n = 58*)



*Percentages are based on a total of 58 calls documented and verified by the Psychiatry department after removing duplicate calls for the same patient.

Figure 4: BERT calls per service line, August-December 2022 (n = 33*)



*The patient service line could only be positively determined for 33 calls due to missing or incorrect information.

Results

A post-BERT Committee was created to evaluate which units placed BERT calls, the responsiveness of the BERT team members, and if the BERT calls were appropriate. There was also discussion and the chance to recommend changes in the process.

Slow start

There were no BERT calls for the first few weeks after the initiation in August 2022. This observation prompted staff reeducation on the BERT through unit-based staffing huddles, email

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reminders, supervisor rounding, and discussion with the charge RNs, nurse administrators, nursing leadership meetings, tiered huddles, and departmental announcements. Subsequently, there was a significant increase in BERT calls to an average of four BERT calls per week.

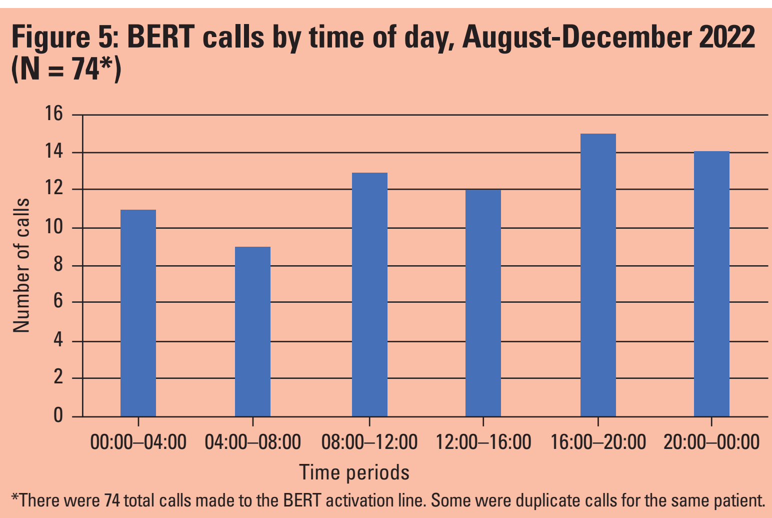
Postimplementation BERT call data analysis

After implementing BERT and having consistent notifications, the team assessed the BERT call times, the reasons for activation (see *Figure 3*), and the number of calls per inpatient unit (see *Figure 4*). During the 5-month evaluation period, there were a total of 74 calls to the BERT activation number. However, some of those were duplicate calls for the same patient. A total of 58 calls were verified after removing duplicates. Of note, delirium was the primary reason for activation. Another US academic medical center has also reported that delirium and dementia were the most common precipitating factors among aggressive patients.[6]

The inpatient units calling most frequently were surgery/rehab, followed by the cardiac, neurology, and medicine units. It's interesting that the medicine units had the lowest frequency of calls because these units initially had the most reported incidents of patient-initiated workplace violence. However, the medicine units already had additional resources, such as the security rounder and embedded psychiatry liaison, whereas the other units embraced the support readily. The times the BERT was activated varied (see *Figure 5*).

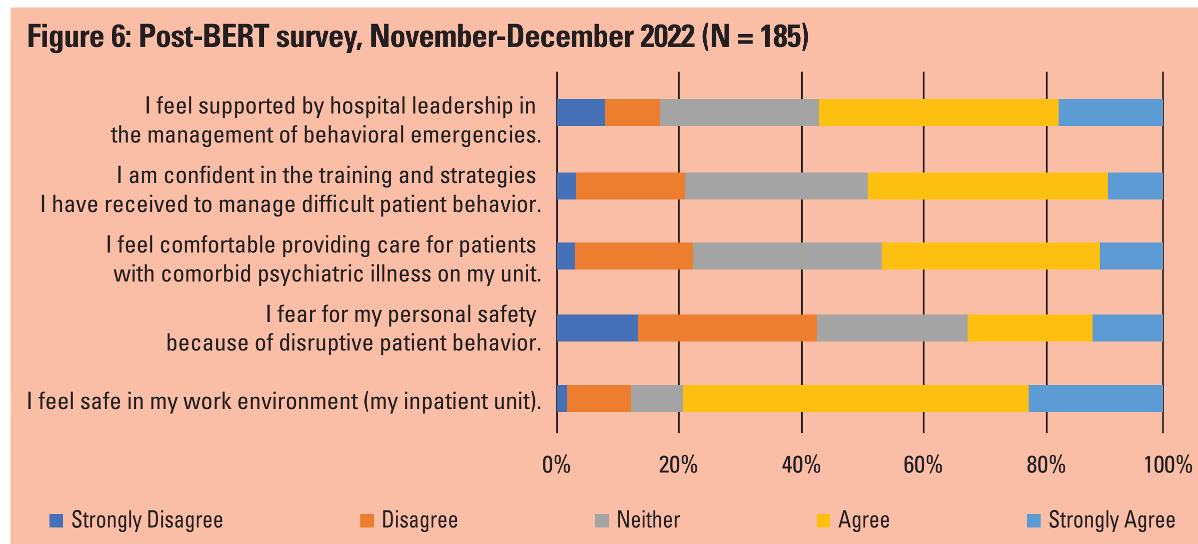
There was also an analysis of the number of patients flagged in the EHR for an elevated risk for violence who also had BERT calls. Flags are entered after a nursing assessment of high risk using a modified Broset Violence Checklist and/or an actual disruptive/violent episode.[7] There were 6 patients flagged out of the 58 BERT calls from initiation until the end of December 2023, a 5-month period. It was apparent

Figure 5: BERT calls by time of day, August-December 2022 (N = 74*)



*There were 74 total calls made to the BERT activation line. Some were duplicate calls for the same patient.

Figure 6: Post-BERT survey, November-December 2022 (N = 185)



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that the flagging system didn't identify the patients who needed the BERT team. Understanding the lack of relationship will inform some of the next steps.

The biggest improvement was a 14% increase in confidence related to training and strategies to manage patient behaviors.

Staff survey pre-post
A post-BERT survey was sent out to inpatient RNs 5 months after the initiation of the BERT, using the same questions and Likert-type scale as the pre-BERT survey. A total of 185 responses were received, showing improvement for all questions (see *Figure 6*). The biggest improvement was a 14% increase in confidence related to training and strategies to manage patient behaviors.

Additionally, a 13% improvement was noted in nursing's perception of safety in the work environment and in personal safety related to disruptive patient behavior. There was a 9% increase in nurses' perceived level of support from hospital leadership during the management of behavioral emergencies. The smallest increase was in the nurses' level of comfort in providing care for patients with comorbid psychiatric illnesses.

Tracking and trending employee harm reports from violent/disruptive patient behavior proved challenging. At the time of this writing, the data included many confounding variables and couldn't be attributed directly to the BERT implementation.

In addition to the benefits described in the survey results, RNs learned de-escalation techniques from observation of the BERT psychiatry team. Additionally, the interdepartmental collaboration to obtain the best outcomes for patients was very helpful.

Verbatim positive feedback
Comments collected from inpatient unit RNs who experienced BERT activations included:

- "The collaboration between Psychiatry and the primary team is amazing and beneficial during these emergency situations. De-escalation techniques provide a great learning opportunity for the staff."
- "Love it...Great help. Wonderful resource. Exceptional service."
- "It works! So helpful to have Security and Psychiatry on board. Very helpful."
- "Psychiatry responds in real-time while the patient is escalating, not hours later when the patient is calm, so patients are medicated appropriately."
- "Helps and protects the staff and patients. Decreased patient and employee harm."

Next steps
With a successful pilot at one campus, the team plans to help expand the BERT pilot from the initial pilot campus to cross-campus implementation. Continued collaboration between Nursing and Psychiatry is needed to develop a delirium intervention/medication protocol. We also plan to investigate the use and effectiveness of flagging patients who are violent in the EHR. Finally, the BERT team will compare the number of WorkSafe entries before and after BERT implementation and investigate causes of workplace violence underreporting.

Safety and support
The success of this BERT pilot program was convincing. The utilization of BERT was intended to optimize patient outcomes, mitigate workplace violence, and provide support for clinical nursing staff. After BERT implementation, nurses felt safer in the workplace environment, feared less for their personal safety, felt more confident when dealing with disruptive/violent patient behaviors, and felt supported by hospital leadership in managing behavioral emergencies. NM

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The authors and planners have disclosed no financial relationships related to this article.

DOI-10.1097/nmg.0000000000000063

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