Rebuild the Foundation for a Resilient Workforce

Best practices to repair the cracks in the care environment

PUBLISHED BY
Nursing Executive Center
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Advisors to Our Work

The Nursing Executive Center is grateful to the individuals and organizations that shared their insights, analysis, and time with us. We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

With Sincere Appreciation

**Advocate Children’s Hospital**  
*Park Ridge, IL*  
Stacey Jutila

**American Nurses Association**  
*Silver Spring, MD*  
Marla Weston

**Children’s Health**  
*Dallas, TX*  
Stacy Smith

**Froedtert & the Medical College of Wisconsin**  
*Milwaukee, WI*  
Kathy Bechtel  
Christine Buth  
Melissa Gregor

**Johns Hopkins University**  
*Baltimore, MD*  
Cynda Rushton

**Main Line Health**  
*Bryn Mawr, PA*  
Barbara Wadsworth  
Kristen Woodruff

**Mission Health**  
*Asheville, NC*  
Chris DeRienzo  
Sonya Greck

**Northumbria NHS Healthcare Foundation Trust**  
*North Tyneside, United Kingdom*  
Paul Drummond  
Jan Hutchinson  
Annie Laverty  
Joanne Mackintosh  
Tracy Young

**Sibley Memorial Hospital**  
*Washington, DC*  
Suzanne Dutton  
Joanne Miller

**Saint Luke’s Hospital of Kansas City**  
*Kansas City, MO*  
Debbie Wilson

**Texas Health Presbyterian**  
*Dallas, TX*  
CaSandra Robinson Williams  
Cole Edmonson

**Valley Children’s Hospital**  
*Madera, CA*  
Linda Miller  
Matt Schwartz  
Ellen Bettenhausen

**Valley Health System**  
*Ridgewood, NJ*  
Daniel Coss  
Patrice Wilson  
Barbara Schultz

**Virginia Commonwealth University**  
*Richmond, VA*  
Ann Hamric

**Michael Garron Hospital**  
*Toronto, Canada*  
Irene Andress

**Sykehuset Østfold**  
*Grålum, Norway*  
Anne Karine Østbye Roos  
Cecilie Kruse-Nilsen
Executive Summary

Frontline Nurses Are Stressed and Burned Out
Nearly three out of four nurses report concerns about stress and overwork, and 70% report feeling burned out. These numbers are alarming because—in addition to negatively impacting nurses’ well-being, stress and burnout are linked to an increase in adverse patient outcomes, lower workforce productivity, and higher rates of nurse turnover.

Health Care Leaders Are Committed to Building Individual Resilience—But It’s Not Sufficient
To reduce frontline stress and burnout, nurse leaders are striving to build individual nurse resilience through engagement and wellness initiatives. In fact, hospitals and health systems have never been more committed to nurse engagement, retention, and wellness. Despite this commitment, these initiatives alone are not sufficient because stress and burnout are still increasing. To solve this problem, health care leaders are now asking: What are we overlooking that is undermining nurse resilience?

“Cracks in the Foundation” Undermine Nurse Resilience
According to Maslow’s hierarchy of needs, individuals can’t reach their full potential if they are struggling with basic needs. In today’s health care environment, there are unaddressed needs—or “cracks in the foundation”—undermining nurse resilience and leading to burnout.

The four foundational cracks are:
• Violence and point-of-care safety threats are now commonplace in health care settings
• Nurses feel they have to make compromises in care delivery
• Staff bounce from traumatic experiences to other care activities with no time to recover
• New technology, responsibilities, and care protocols cause nurses to feel “isolated in a crowd”

Use this Excerpt to Start Addressing Violence and Point-of-Care Safety Threats
To build a more resilient nursing workforce, leaders must repair all four cracks in the foundation of the health care environment. This excerpt includes resources to help you get started.

Keep reading to get our analysis of what’s causing nurse burnout and to get an easy-to-use tool that can help frontline staff assess a patient or family member’s likelihood for behavioral escalation. Frontline staff can use our tool to identify early signs of disruptive behavior and proactively intervene before behavior escalates.
Spotlighting Cracks in the Care Environment
Nurses around the world are stressed, overwhelmed, and burned out. Mounting evidence shows that stress and overwork are widespread across the nursing profession. As shown here, this can cause work-related fatigue and contribute to growing rates of frontline burnout. In Advisory Board interviews, frontline nurses confirm that they now see stress and burnout as an everyday reality.

Sample Evidence of Frontline Nurse Stress and Burnout

<table>
<thead>
<tr>
<th>More Stress and Overwork</th>
<th>Growing Work-Related Fatigue</th>
<th>Increased Burnout</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td>49%</td>
<td>70%</td>
</tr>
<tr>
<td>Of nurses report concern about stress and overwork¹</td>
<td>Of nurses report feeling tired all the time²</td>
<td>Of nurses report feeling burned out²</td>
</tr>
</tbody>
</table>

“The only prevailing nursing model we have in American hospitals is **FRED: frantically running every day.** Medical-surgical units, labor and delivery units—all units—I see stress going up.”

*Frontline Nurse*

1) n = 4,614; 2011.  
2) n = 93; 2017.  
3) n = 600; 2017.

Quantifying Current Costs of Frontline Burnout

In addition to having a negative impact on nurses’ well-being, work-related stress and burnout are currently costing your organization. The two key ways nurse burnout is impacting hospitals and health systems are shown here.

First, burnout decreases workforce productivity. Burned out nurses are more likely to miss work due to exhaustion or illness. In addition, burnout is associated with a decrease in overall efficiency while at work.

Second, burnout impacts patient outcomes. A higher rate of burnout among clinicians is linked to an increase in health care-associated infections. For example, for every 10% increase in the number of burned out nurses at an organization, the rate of urinary tract infections increases by nearly 1 per 1,000 patients. Additional clinical outcomes, including surgical site infections and medication errors, are also associated with frontline nurse burnout.

In addition to the current cost burden shown here, Advisory Board analyses also predict future costs. The next page details these projections and their potential impact.

1) For every 10% increase in burned-out nurses in a hospital, the rate of urinary tract infections increases by nearly 1 per 1,000 patients; the rate of surgical site infections increases by more than 2 per 1,000 patients. These findings are both statistically and clinically significant.

2) Cost associated with this hospital-acquired infection are not covered by Medicare or Medicaid.

Over time, stress and burnout can also cost your organization due to increased nurse turnover.

This is particularly alarming for organizations given the projected nursing shortage. The Bureau of Labor Statistics estimates that the United States needs 1.2 million new RNs to avoid a nursing shortage in 2022. While some of the shortage is due to retirements, there are many nurses leaving for other reasons, including stress. A recent study found that 50% of nurses are considering leaving the profession, primarily because of stress. As a result, it may become increasingly difficult to fill vacant RN positions in the future.

The financial impact of nurse turnover is summarized here. On average, it costs an organization $90,000 for a single RN departure. The exact cost of turnover at your organization can vary due to individual factors, such as replacement labor and recruitment expenses. Regardless, these numbers are alarming at a time when organizations have never been more careful about spending.


1) Projected by the Bureau of Labor Statistics.
2) Turnover costs at least 1.5 times the annual salary of the position. The exact cost of turnover for an individual position varies, depending on the following factors: separation expenses (such as continued benefits, accrued vacation time), replacement labor expenses (contract, agency, or overtime hours), recruitment expenses, onboarding expenses, lost revenues (lost incremental revenues associated with vacant position—for example, bed closures or ED diversions). RN turnover costs a hospital between $5.2M–$8.1M annually, n=138 hospitals.
3) Average total cost of RN turnover per hospital per year
Resilience Protects Staff from Burning Out

As a result of increasing rates of frontline stress and burnout, it’s not surprising that a top priority for nurse leaders is to increase frontline nurse resilience.

Resilience is defined as the ability to remain agile and effective amid stress and bounce back quickly from difficult situations. It acts as a buffer to protect nurses from becoming overwhelmed and burned out.

While most nurses already have a high level of resilience, many health care organizations have taken steps to further build individual resilience to help manage stress. These steps are detailed on the next page.

**CNO and Frontline Perspectives on Nurse Resilience**

“Nurses are the foundation of hospitals and health care. They’re the group that holds it all together. They’re the most **resilient** crowd.”

*Chief Nursing Officer*

“I see nurses’ **resilience** every day. They negotiate the demands of the job and deal with the high stress, but still walk into patients’ rooms with a smile.”

*Frontline Nurse*

Source: Nursing Executive Center interviews and analysis.
To build the resilience of individual nurses, most organizations focus on the two strategies described below.

First, health care leaders have increased their engagement efforts. For example, strategies and tactics from Advisory Board and the Nursing Executive Center have been used in the development of more than 14,000 action plans for engagement and retention. Focusing on engagement is a logical first step: when nurses are more engaged, they are more resilient and less likely to feel burnout.

Second, health care leaders have increased their organization's investments in employee wellness initiatives. These include programs to build resilience, relieve stress, promote healthy choices, and improve sleep hygiene.

Unfortunately, these strategies alone are not sufficient. At a time when hospitals and health systems have never been more committed to engagement, retention, and wellness, rates of stress and burnout among nurses around the world are increasing.

Health care leaders are now asking: Are we overlooking something that is undermining nurse resilience? The next page provides an answer.

Two Strategies to Improving Employee Engagement and Wellness

14,000+
Number of engagement action plans created through Advisory Board’s online action planning tool

87%
Percentage of hospitals with health and wellness programs

The Nursing Executive Center has several resources on workforce engagement and retention, including: Win Millennials’ Loyalty, The First Year Retention Toolkit, The National Prescription for Nurse Engagement, and Put an End to Nurse Manager Overload. To learn more, contact us at programinquiries@advisory.com.


1) Survey completed by 1,140 U.S. hospital human resource leaders, CEOs, and wellness leaders in 2015.
Remember Maslow’s Hierarchy of Needs

Maslow’s hierarchy of needs is a well-known theory that proposes there is a hierarchy, or an order, of how specific needs must be fulfilled for individuals to be their best. According to this model, all humans have basic and psychological needs that must be met before they can grow professionally and reach their full potential.

The two main strategies health care leaders have disproportionately focused on—engagement and wellness initiatives—are at the top of the Maslow’s hierarchy. While these are critical for addressing advanced needs, this approach assumes nurses’ basic needs are already being met.

The problem is: nurses’ basic needs are not being met. In today’s care environment, there are unaddressed needs, or “cracks in the foundation,” undermining nurse resilience and leading to frontline burnout. These cracks in the foundation jeopardize everything built on top of it. No matter how much organizations focus on engagement, wellness, and individual resilience training, the nursing workforce will continue to struggle with stress and burnout until the foundation is fixed and basic needs are met.

To reduce frontline stress and burnout, nursing leaders should invest in targeted strategies to fix the cracks in the foundation currently undermining nurse resilience. To do so, they must first identify the cracks in the foundation.

Summary of Maslow’s Hierarchy of Needs

<table>
<thead>
<tr>
<th>Basic Needs</th>
<th>Safety Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The need to feel physically safe, including personal, financial, health,</td>
</tr>
<tr>
<td></td>
<td>and adverse events</td>
</tr>
<tr>
<td>Psychological Needs</td>
<td>Physiological Needs</td>
</tr>
<tr>
<td></td>
<td>The physical requirements for human survival, including air, food, and water</td>
</tr>
<tr>
<td>Self-Fulfillment Needs</td>
<td>• Self Actualization: The need to achieve one’s full potential, including</td>
</tr>
<tr>
<td></td>
<td>creative activities</td>
</tr>
<tr>
<td>• Esteem: The need to</td>
<td>• Social Belonging: The need to feel a sense of belonging and acceptance</td>
</tr>
<tr>
<td>feel respected,</td>
<td>among social groups, including friendships and family</td>
</tr>
<tr>
<td>the need to have self-</td>
<td>• Safety Needs: The need to feel physically safe, including personal,</td>
</tr>
<tr>
<td>esteem and self-respect</td>
<td>financial, health, and adverse events</td>
</tr>
</tbody>
</table>

Four Cracks in the Foundation

To identify the cracks in the foundation, the Nursing Executive Center conducted focus groups with frontline nurses, interviewed nursing and other health care leaders, and consulted with resilience experts. This process surfaced four changes in the health care environment that make it challenging for frontline nurses to remain resilient in today’s care environment.

The first foundational crack is that violence and point-of-care safety threats are now commonplace in health care settings. As a result, nurses don’t always feel safe when they’re at work.

The second foundational crack is that nurses feel they have to make compromises in care delivery. When nurses enter their profession, they make a commitment to provide safe care and do no harm. But sometimes they feel like institutional constraints prevent them from providing the best care for their patients. As a result, nurses experience moral distress.

The third foundational crack is that staff bounce from traumatic experiences to other care activities with no time to recover. This is because clinicians have more care activities to do in less time and prioritize patient care over their own emotional well-being.

The fourth foundational crack is that nurses feel isolated in a crowd. Changes in care delivery processes, such as new technology, responsibilities, and care protocols, have led to more isolated work streams. This results in nurses feeling like they are working alone rather than as a team.

The following two pages provide the solvable challenges within each of these foundational cracks and best practices for overcoming them.

Four Cracks in Today’s Care Environment

1. Violence and **point-of-care safety threats** are now commonplace in health care settings

2. Nurses feel they have to make **compromises in care delivery**

3. Staff bounce from traumatic experiences to other care activities with **no time to recover**

4. New technology, responsibilities, and care protocols cause nurses to feel **“isolated in a crowd”**
Rebuild the Foundation for a Resilient Workforce

This page outlines the Nursing Executive Center’s playbook for rebuilding the foundation for a resilient workforce.

The first column contains the four foundational cracks that make it difficult for nurses to be resilient in today’s care environment. The second column provides the solvable challenge related to each foundational crack; the solvable challenge is what leaders can address with the best practices in this publication. The solvable challenges meet two criteria: they are within your power to realistically impact and will solve at least the “80/20” of each foundational crack.

The final two columns give nurse leaders strategies and best practices to address each solvable challenge. The remainder of this report provides further detail on each foundational crack and offers guidance on the strategies and best practices.

<table>
<thead>
<tr>
<th>Foundational Crack</th>
<th>Solvable Challenge</th>
<th>Executive Strategy</th>
<th>Best Practices</th>
</tr>
</thead>
</table>
| Violence and point-of-care safety threats are now commonplace in health care settings | Nurses don’t feel equipped to respond to routine point-of-care safety threats    | Reduce response time to routine point-of-care threats     | 1. **Disruptive behavior algorithm**  
2. Security-driven unit rounding  
3. Frontline de-escalation team  
4. Behavioral health emergency response team |
| Nurses feel they have to make compromises in care delivery                        | Nurses perceive that staffing levels are unsafe                                   | Surface and address perceptions of unsafe staffing        | 5. Staffing assumptions leadership exercise  
6. Frontline moral distress consult |
| Staff bounce from traumatic experiences to other care activities with no time to recover | Nurses don’t use services that can help them debrief, process, and recover from traumatic experiences | Make emotional support opt-out only                      | 7. Manager-triggered psychological first aid  
8. Embedded emotional support bundle |
| New technology, responsibilities, and care protocols cause nurses to feel “isolated in a crowd” | Nurses do not connect in meaningful ways with peers                                | Reconnect nurses through storytelling                     | 9. 90-second storytelling  
10. Routine clinical reflections |

**Special Report: Addressing Incivility**

11. Float nurse unit civility survey  
12. Staff-driven code of conduct

Source: Nursing Executive Center interviews and analysis.
Reduce Response Time to Routine Point-of-Care Threats

• Practice 1: Disruptive Behavior Algorithm
• Practice 2: Security-driven Unit Rounding
• Practice 3: Frontline De-escalation Team
• Practice 4: Behavioral Health Emergency Response Team
The first foundational crack undermining nurse resilience is that violence and point-of-care safety threats are now commonplace in health care settings. Violence in health care settings has always been a challenge. But, as shown in the data here, it is occurring more often.

### Violence in Health Care Settings on the Rise

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td>Security professionals report maintaining safety is more challenging than in year prior 1</td>
</tr>
<tr>
<td>110%</td>
<td>Increase in rate of reported incidents of violence against health care workers 2</td>
</tr>
<tr>
<td>25%</td>
<td>Nurses report being physically assaulted by a patient or family member</td>
</tr>
</tbody>
</table>

“"We’re seeing more incidences of workplace violence because hospitals are a reflection of greater society. We’re a microcosm of society.”

*Chief Nursing Officer, U.S. Hospital System*

“"Occupational violence is a real threat to resilience. Nurses are prepared to accept that this is something that shouldn’t happen but does happen in their line of work.”

*Director of Nursing and Midwifery, Australian Public Hospital*

In response, many organizations are already investing in resources to keep staff safe, including active shooter protocols and more security personnel. Despite these investments, nurses do not always feel safe at work because of frequent violence and aggression from patients and families at the point of care.

Leaders can’t prevent point-of-care violence. But, there is a solvable challenge, which is described on the next page.

54%  
Of surveyed organizations in the U.S. increased security budgets in 2016

$775,000  
Median annual budget for physical security in U.S. health care industry 1

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1) In 2016 vs. 2015.  
2) Increase in rate occurred from 2005 to 2014.

The solvable challenge that leaders can address is that nurses don’t feel equipped to respond to routine point-of-care safety threats.

Point-of-care violence can be relatively minor (for example, verbal assault) or serious, as described below. While the nurse depicted here was not physically injured, the example demonstrates how routine patient care activities can quickly escalate into violence.

“We had a nurse who was assaulted by a patient recently. She was assisting the patient in going to the bathroom. She was not near the panic button. The door was shut to afford the patient privacy, and the patient picked her up by her neck and strangled her.”

Chief Nursing Officer and VP of Patient Care, U.S. Hospital

Unfortunately, frontline staff don’t always know what to do when they feel threatened at the point of care. The next page discusses how leaders can address point-of-care violence.
To adopt the executive strategy of reducing response time to routine point-of-care threats, leaders need to address the two root causes that delay a security response to point-of-care violence, which are shown below.

**Two Root Causes of Delayed Security Response**

- **Responders can’t get there quickly**
  Limited number of security personnel can’t get to threatened staff quickly because they cover a large geographic area.

- **Behavioral health patients need a specialized response**
  Limited number of staff are trained to respond to behavioral health patients in crisis, slowing response time.

The first root cause is that responders can’t get to the point-of-care quickly because many health care facilities have a large geographic footprint and a limited number of security personnel. As a result, response time is slow because security personnel must travel across a large facility.

The second root cause is that behavioral health patients need a specialized response when in acute crisis. However, many organizations have a limited number of clinicians qualified to respond—and they may not be available in the moment to help de-escalate threatening behaviors.

**The following excerpt of our full report provides an easy-to-use tool that can help frontline staff assess a patient or family member’s likelihood for behavioral escalation.**

Source: Nursing Executive Center interviews and analysis.
Practice 1: Disruptive Behavior Algorithm

Practice in Brief
Provide frontline staff with an easy-to-use tool that assesses a patient or family member’s likelihood for behavioral escalation and includes predetermined action steps based on the severity of the behavior. The goal is to identify early signs of disruptive behavior and proactively intervene before they escalate.

Rationale
Disruptive patients or family members often display minor aggressions and other warning signs before their behavior escalates in severity. However, many frontline staff don’t report these incidents—either because they feel disruptive behavior is “part of the job” or they are unsure what behavior warrants reporting. As a result, disruptive behavior often isn’t reported until it’s too late. By providing a simple behavior assessment tool, organizations can help staff better identify early warning signs and intervene before behavior escalates.

Implementation Components

Component 1: Give frontline staff an easy-to-use tool to assess disruptive behaviors
Provide frontline staff with a tool to determine if patients or family members are displaying disruptive behaviors. The tool should categorize behaviors based on severity—from least to most severe—and be easy to incorporate into existing patient assessments.

Component 2: Provide clear action steps for disruptive behaviors
Outline predetermined action steps for frontline staff to follow when a patient or family member meets criteria for at least one disruptive behavior. Action steps are calibrated based on the level of severity.

Component 3: Reinforce frontline use of the assessment tool
Encourage staff to regularly use the Disruptive Behavior Algorithm during unit huddles and leader rounding. Ensure staff understand the rationale for the assessment and how it helps keep them safe.

Practice Assessment
Disruptive behavior is a widespread issue in health care facilities, but it is often under-reported. We recommend this practice for all organizations to improve reporting of disruptive behaviors and prevent incidents of point-of-care violence. The work required to create an organization-specific assessment tool is minimal.

Source: Nursing Executive Center interviews and analysis.
Many frontline staff don’t report low-level disruptive behavior from patients or family members. Therefore, security personnel and leaders are often unaware of threats on the unit or are notified when disruptive behavior has already escalated into violence. As a result, frontline staff and responding security personnel are at higher risk for injury.

### Insufficient Reporting

30%

Estimated percentage of nurses\(^1\) who report incidents of violence

### A Culture of Silence

There can be no excuse for abusing or assaulting staff and all incidents should be taken very seriously. Sadly, **violence on NHS premises often go unreported and many workers are left to suffer in silence.**

*Representative, UNISON*

Frontline staff don’t report threatening or violent behaviors for many reasons, some of which are shown here.

### Common Reasons for Under-Reporting Violence

- **Resignation**: Staff think violence is "part of the job"
- **No Clear Impact**: Staff don’t believe reporting will change anything
- **Uncertainty**: Staff are unsure if and when they should report

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1) Surveyed US nurses.
Staff Are Unsure Which Behaviors to Report

It’s challenging for staff to know which behaviors warrant reporting because there are many common behaviors that can escalate into violence, as shown here. Often, frontline staff do not have clear guidance on which behaviors to report or how to report them.

Examples of Patient and Family Behaviors That Can Escalate into Violence

- Raising voice or yelling
- Invading staff’s personal space
- Appearing very angry about everything
- Threatening lawsuits
- Interfering with patient care
- Witnessing visible discord among family
- Refusing discharge
- Using verbally aggressive language
- Appearing under the influence of drugs or alcohol

Sharp Grossmont Hospital, an acute care hospital in La Mesa, California, developed a decision-making tool to help frontline staff identify and appropriately report disruptive behaviors. The key components of this practice are listed on the next few pages.

Source: Nursing Executive Center interviews and analysis.
Component 1: Give frontline staff an easy-to-use tool to assess disruptive behaviors

The first component of this practice is to provide frontline staff with a tool to determine if patients or family members are displaying disruptive behaviors. An excerpt of Sharp Grossmont Hospital’s tool is shown here.

At Sharp Grossmont Hospital, nurses use this tool to evaluate patients and family members as part of intake, the daily nursing assessment process, or as needed. The tool categorizes behaviors into three levels based on severity—from least to most severe. These behavior levels have corresponding action steps, which are detailed on the next page.

Sharp Grossmont Hospital’s Disruptive Behavior Levels

Use the chart below to assess the patient/family for their ability to cope with the hospitalization.

<table>
<thead>
<tr>
<th>Behavior Level 1</th>
<th>Behavior Level 2</th>
<th>Behavior Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient/family refusing discharge</td>
<td>• Patient/family very angry about “everything”</td>
<td>• Violent behavior including raised voice, verbal threats, invading personal space, or threatening gestures</td>
</tr>
<tr>
<td>• Family communicates visitor restrictions</td>
<td>• Family or visitors interfere with patient care</td>
<td>• Staff feel threatened or do not feel safe to enter the room alone</td>
</tr>
<tr>
<td>• Patient/family appear confused about plan of care</td>
<td>• Family or visitors appear under the influence</td>
<td>• History of code green</td>
</tr>
<tr>
<td>• Family overwhelmed and unable to take part in decision-making</td>
<td>• Visible discord among patient or family</td>
<td>• Assaultive behavior</td>
</tr>
<tr>
<td>• 5150 danger to self or others</td>
<td>• Excessive worry expressed by family members</td>
<td></td>
</tr>
</tbody>
</table>

Disruptive behaviors clearly outlined to help staff easily identify early warning signs

Three levels help staff determine the most appropriate next steps

► Access Sharp Grossmont Hospital’s Disruptive Behavior Algorithm and Process Flow Chart [here](#)
Component 2: Provide clear action steps for disruptive behaviors

The second component of this practice is to outline predetermined action steps for frontline staff to follow when a patient or family member meets criteria for at least one disruptive behavior. A representation of Sharp Grossmont Hospital’s disruptive behavior action steps is shown here.

Sharp Grossmont Hospital’s Disruptive Behavior Action Steps

Nurse activates action step based on behavior level determined during daily assessment

Level 1 Action Steps
- RN contacts unit manager
- Patient care conference with full care team
- Behavioral treatment plan optional
- Unit manager flags disruptive patients at daily huddle

Level 2 Action Steps
- RN contacts unit manager
- Patient care conference with full care team
- Behavioral treatment plan optional
- Unit manager flags disruptive patients at daily huddle
- Unit manager notifies director of disruptive patients

Level 3 Action Steps
- RN contacts unit manager
- Patient care conference with full care team
- Behavioral treatment plan required
- Unit manager flags disruptive patients at daily huddle
- Unit manager notifies director of disruptive patients
- Director notifies CNO/COO of disruptive patients
- Security assesses need for “show of concern” or sitter

Action steps are calibrated based on the level of severity and can include: notifying the unit manager and other clinical leaders, implementing a behavioral treatment plan, and requesting a security response. The next page discusses Sharp Grossmont Hospital’s behavioral treatment plans in more detail.

1) Administrative liaison is contacted if it’s after hours or a weekend.
2) Or administrator on call if after hours or a weekend.

Source: Sharp Grossmont Hospital, La Mesa, CA; Nursing Executive Center interviews and analysis.

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An excerpt of Sharp Grossmont’s behavioral treatment plan is shown here. The goal of behavioral treatment plans is to ensure all frontline staff know if a patient or family member has a history of disruptive behavior, even after a change of shift or when a patient transfers to a new care setting. Behavioral treatment plans include a description of the disruptive behavior and associated actions taken by staff.

At Sharp Grossmont Hospital, behavioral treatment plans are required for patients or family members displaying level 3 behaviors (see page 24). These treatment plans are optional for level 1 or 2 behaviors, based on the unit manager’s discretion. Behavioral treatment plans remain with a patient when transferred to different units or care sites. Following discharge, a copy of the behavioral treatment plan is kept on administrative file for future reference, should the patient be readmitted.

Excerpt of Sharp Grossmont Hospital’s Behavior Treatment Plan

To access Sharp Grossmont Hospital’s full behavioral treatment plan template and additional resources, visit advisory.com/nec/resilience
Component 3: Reinforce frontline use of the assessment tool

The third component of this practice is to encourage staff to regularly use the Disruptive Behavior Algorithm during unit huddles and leader rounding. This helps ensure staff understand the rationale for the assessment and how it helps keep them safe. At Sharp Grossmont Hospital, leaders also keep staff safety a top priority in the three ways shown here.

Sharp Grossmont Hospital's Approach to a Culture of Staff Safety

Training on disruptive patients for all clinical staff
All licensed and unlicensed clinical staff are trained on disruptive patients, how to identify early warning signs, how to use the Disruptive Behavior Algorithm, and guidance on staying safe at the point-of-care.

Updating leaders at daily huddles
All disruptive behavior is reported by the unit manager during the morning safety huddle, which includes representatives from each unit, the C-suite, and security. Executive leaders and security personnel are proactively notified about potential risks at the point of care.

Consistent messaging to managers and staff
Leaders use consistent messaging about staff safety during unit rounds. For example, executives ask staff about disruptive patients when rounding on the unit, and reinforce the value of the assessment tool.

Source: Sharp Grossmont Hospital, La Mesa, CA; Nursing Executive Center interviews and analysis.
Early Reporting Helps Reduce Staff Injury

After introducing the Disruptive Behavior Algorithm, staff injuries due to combative patients dropped significantly at Sharp Grossmont Hospital. Nursing leaders attribute this reduction to earlier reporting of disruptive patients and family members.

Number of Staff Injuries Due to Combative Patients, Sharp Grossmont Hospital

2015

2017

68% Decrease

Source: Sharp Grossmont Hospital, La Mesa, CA; Nursing Executive Center interviews and analysis.
Related resources available with membership

**Implementation resource:** [Nurse Manager Time Audit](#)
Use this set of tools to accurately assess how nurse managers are using their time, allowing for delegation and support when necessary.

**Research report:** [Create Care Standards your Frontline Nurses will Embrace](#)
Get 12 tactics for care standard prioritization, design, and rollout.

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