



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

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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”

Read This Report in Full to Learn How to Address These Foundational Cracks

To build a more resilient nursing workforce, leaders must repair these four cracks in the foundation of the health care environment. This report includes executive strategies and best practices to repair each foundational crack. The bulk of this report draws from the U.S. health system, but we have included some examples from other countries, as nursing resilience is a global issue.

▶ **Spotlighting Cracks
in the Care Environment**

Frontline Nurses Are Stressed and Burned Out

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

More Stress
and Overwork



75%

Of nurses report concern about stress and overwork¹

Growing Work-
Related Fatigue



49%

Of nurses report feeling tired all the time²

Increased
Burnout



70%

Of nurses report feeling burned out³

“

“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.

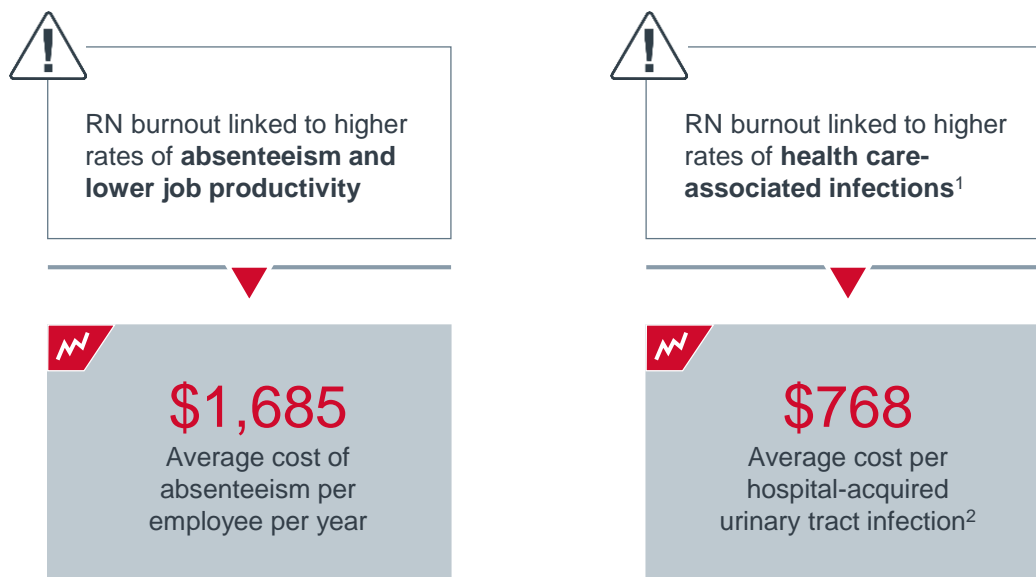
Source: “2011 ANA Health and Safety Survey,” American Nurses Association, 2011, <http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/Work-Environment/2011-HealthSafetySurvey.html>; Masterson L, “Nurses are burnt out. Here’s how hospitals can help,” *Healthcare Dive*, May 12, 2017, <https://www.healthcaredive.com/news/nurses-are-burnt-out-heres-how-hospitals-can-help/442640/>; Nursing Executive Center interviews and analysis.

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.

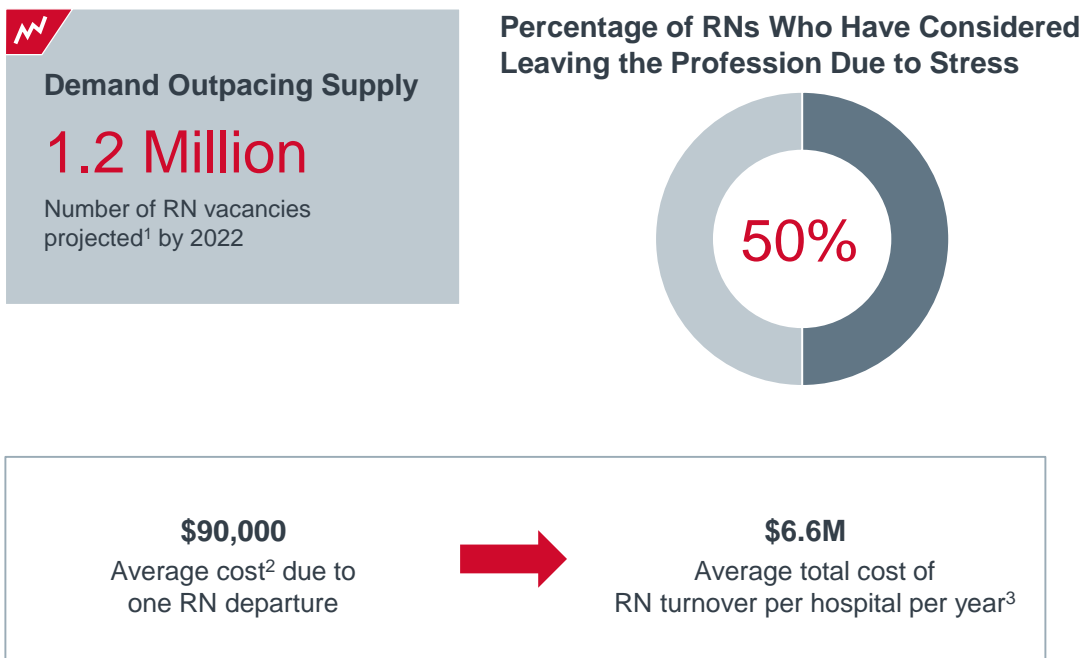
Source: Dyrbye L, et al., "Burnout Among Health Care Professionals: A Call to Explore and Address This Under-recognized Threat to Safe, High-Quality Care," National Academy of Medicine, July 5, 2017, <https://nam.edu/burnout-among-health-care-professionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care/>; "Workplace Health Promotion," Centers for Disease Control and Prevention, 2015, <https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2015/aag-workplace-health.pdf>; Cimino JP, et al., "Nurse staffing, burnout, and health care-associated infection," *American Journal of Infection Control*, August 2012. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3509207/>; Nursing Executive Center interviews and analysis.

Projecting Future Costs of Frontline Burnout

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).

3) RN turnover costs a hospital between \$5.2M – \$8.1M annually; n = 138 hospitals

Source: Mulero A, "Survey: Nearly half of nurses might leave the profession," *Healthcare Dive*, March 1, 2017, <https://www.healthcaredive.com/news/survey-nearly-half-of-nurses-might-leave-the-profession/437122/>; "Nursing Shortage," American Nurses Association, <http://www.nursingworld.org/nursingshortage>; Grant R, "The U.S. Is Running Out of Nurses," *The Atlantic*, February 3, 2016, <https://www.theatlantic.com/health/archive/2016/02/nursing-shortage/459741/>; "2016 National Healthcare Retention & RN Staffing Report," Nursing Solutions, Inc., <http://www.nsinursingsolutions.com/Files/assets/library/retention-institute/NationalHealthcareRNRetentionReport2016.pdf>; Nursing Executive Center interviews and analysis.

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.

Invested Deeply in Workforce Engagement and Wellness

To build the resilience of individual nurses, most organizations focus on the two strategies described below.

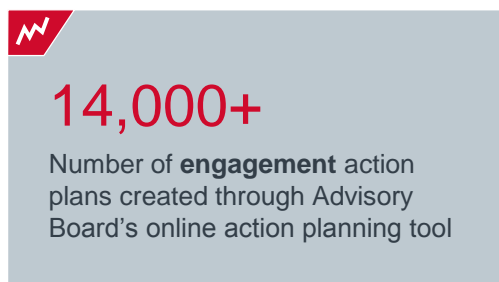
First, health care leaders have increased their engagement efforts. For example, strategies and tactics from Advisory Board and the Nursing Executive Center have been used in the development of more than 14,000 action plans for engagement and retention. Focusing on engagement is a logical first step: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

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



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 access these resources, visit advisory.com/nec/publications

1) Survey completed by 1,140 U.S. hospital human resource leaders, CEOs, and wellness leaders in 2015.

Source: "A Call to Action: Creating a Culture of Health," American Hospital Association, 2016, <http://www.hpoe.org/Reports-HPOE/2016/2016-Health-and-Wellness-Brief-FINAL-10-12-16.pdf>; "2017: Year of the Healthy Nurse," American Nurses Association, 2017, <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/2017-Year-of-Healthy-Nurse>; Nursing Executive Center interviews and analysis.

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



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.



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"**

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

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.

Foundational Crack	Solvable Challenge	Executive Strategy	Best Practices
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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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

Point-of-Care Safety Threats Now Commonplace

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.



“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.



Source: “2016 Hospital Security Survey report,” Health Facilities Management, October 5, 2016, <https://www.hfmmagazine.com/articles/2500-hospital-security-survey-landing-page>; American Nurses Association, “Executive Summary: American Nurses Association Health Risk Appraisal,” 2017, <http://www.nursingworld.org/HRA-Executive-Summary>; Campbell AF, “Why Violence Against Nurses Has Spiked in the Last Decade,” *The Atlantic*, December 1, 2016, <https://www.theatlantic.com/business/archive/2016/12/violence-against-nurses/509309/>; Nursing Executive Center interviews and analysis.

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

Not Equipped to Handle Bedside Safety Threats

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.

Reduce Response Time to Routine Point-of-Care Threats

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



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 section covers four best practices that address these root causes. The first three practices target the first root cause and the fourth practice addresses both root causes described here.

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.

Nursing Executive Center Grades:

Practice Impact: A

Ease of Implementation: A-

Point-of-Care Violence Is Often Not Reported

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 nurses¹ 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
--	---	--









Source: Phillips, J.P., “Workplace Violence against Health Care Workers in the United States,” *The New England Journal of Medicine*, <http://www.nejm.org/doi/full/10.1056/NEJMr1501998>; Glanfield, E., “Eight NHS workers are ‘attacked every hour’: Number up by 9% in a year with most assaults coming as staff try to treat patients,” *Daily Mail*, <http://www.dailymail.co.uk/news/article-2846935/Eight-NHS-workers-attacked-hour-Number-9-year-assaults-coming-staff-try-treat-patients.html#ixzz590SNgdoM>; Nursing Executive Center interviews and analysis.

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	 Threatening lawsuits	 Refusing discharge
 Invading staff's personal space	 Interfering with patient care	 Using verbally aggressive language
 Appearing very angry about everything	 Witnessing visible discord among family	 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.

Clear Guidelines Remove Uncertainty in Reporting

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.

Behavior Level 1	Behavior Level 2	Behavior Level 3
<ul style="list-style-type: none"> • Patient/family refusing discharge • Family communicates visitor restrictions • Patient/family appear confused about plan of care • Family overwhelmed and unable to take part in decision-making • 5150 danger to self or others 	<ul style="list-style-type: none"> • Patient/family very angry about "everything" • Family or visitors interfere with patient care • Family or visitors appear under the influence • Visible discord among patient or family • Excessive worry expressed by family members 	<ul style="list-style-type: none"> • Violent behavior including raised voice, verbal threats, invading personal space, or threatening gestures • Staff feel threatened or do not feel safe to enter the room alone • History of code green • Assaultive behavior

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

Three levels help staff determine the most appropriate next steps

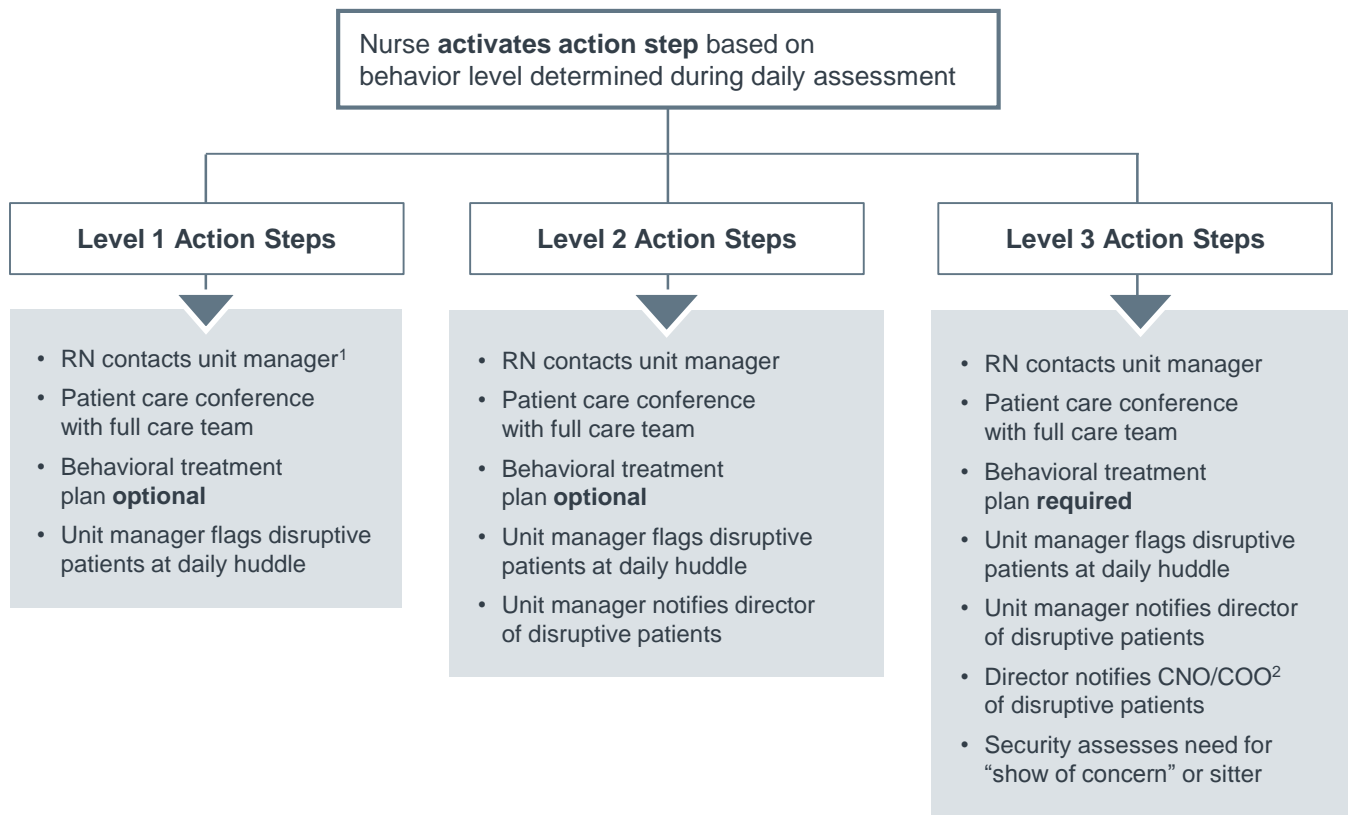
▶ To access Sharp Grossmont Hospital's Disruptive Behavior Algorithm and Process Flow Chart, visit advisory.com/nec/resilience

Make Early Intervention Automatic

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



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.

Track Interventions for At-Risk Patients

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

Disruptive Patient Treatment Plan

Patient Name _____ Legal Status: 5150 14D 30D PCON

Patient Expectations

- Compliant with Plan of Care including _____
- Follow safety precautions including _____
- Respect personal space of others
- Respectful to staff including no yelling, profanity
- No threatening or violent behavior
- Maintain in Hospital gown & foot wear

Consequences for noncompliance include: _____

Activity

- Mobility/Chair Expectations: _____
- Diversion Activities: _____

Restraints/Sitters

- Indication for Restraints: _____
- Restraint Type: _____
- Sitter Type: Male Female Security Other _____

Belongings

- Remove all potentially harmful belongings
- Remove all belongings
- Other: _____

Document Daily for belongings removal: "Removal of belongs is exercised to prevent injury to the patient, others, or facility if there is no less restrictive way to protect those interests"

Medications

- Medicate using the following medication regimen per MD order:
 - Medication Name: _____
 - Frequency: _____
 - Route: _____
 - Indication: _____
 - Hold for: _____
 - Assess for effect of medication: _____

▶ To access Sharp Grossmont Hospital's full behavioral treatment plan template and additional resources, visit advisory.com/nec/resilience

Keep Staff Safety on Everyone's Mind

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.



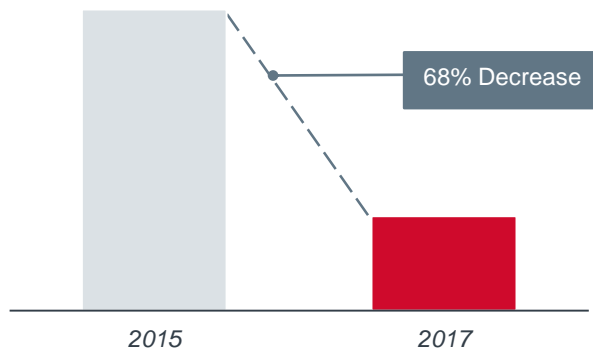
Consistent messaging to managers and staff

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.

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**



Practice 2: Security-Driven Unit Rounding

Practice in Brief

Formalize a process for security personnel to “round” on each unit and conduct brief check-ins with nursing staff. The goal is to proactively flag potential safety issues on each unit so security personnel can prioritize where they patrol more frequently.

Rationale

Most organizations have security personnel patrolling throughout the facility at all times. During patrols, security personnel often focus on facility security, such as locks, lighting, and surveillance systems. As a result, security personnel often don’t know about disruptive patients and family members on a unit until an incident occurs and staff are already at risk. By formalizing check-ins with unit staff during regular patrols, security personnel can identify potential safety concerns and prioritize hot spots of concern—so they can proactively intervene or be nearby if an incident occurs.

Implementation Components

Component 1: Formalize a check-in between security personnel and unit staff during regular patrols

During the check-in, security personnel learn about potential safety issues on the unit, such as disruptive patients or family members.

Component 2: Equip security personnel to prioritize areas of concern in ongoing patrols

Security personnel more frequently patrol units where staff have flagged potential safety concerns. Security personnel adjust patrols throughout their shift as new issues arise or ongoing issues are resolved.

Component 3: Hardwire knowledge transfer at security shift change

Security personnel record key details from their check-ins with staff—including location, nature of threat, and contact person on the unit—and pass on this information to on-coming security personnel at shift change.

Practice Assessment

This is an effective way to maximize the impact of security patrols without additional FTEs. However, this practice requires nursing leaders to work closely with security leaders to adjust current patrol practices and promote buy-in across nursing and security staff.

Nursing Executive Center Grades:

Practice Impact: B+

Ease of Implementation: A

Standard Security Patrols Often Fall Short

Most organizations have security personnel who regularly patrol the facility. However, standard security patrols often fall short of protecting staff due to the two reasons shown here.

First, standard patrols are often conducted at random. Security personnel try to cover as much ground as possible during patrols, splitting time equitably across all areas rather than focusing on specific high-risk units. As a result, they may be on the other side of a facility when an incident occurs.

Second, security personnel's primary focus during patrols is building security: checking doors, locks, stairwells, lighting, and surveillance systems. While these are important security features for an organization, they don't always protect staff from point-of-care threats.

Two Common Pitfalls of Hospital Security Patrols



Conducted at random

Security patrols hallways but aren't always nearby when incidents occur



Primary focus on building security

Security spends majority of time checking doors, locks, stairwells, lighting, and surveillance systems

Texas Health Presbyterian, an 875-bed acute care hospital in Dallas-Fort Worth, Texas, redesigned security patrols to focus on proactively covering “hot spots” of safety threats. The key components of this practice are listed on the following page.

Maximize Effectiveness of Security Rounding

The first component of this practice is to formalize a check-in between security personnel and unit staff. During the check-in, security personnel learn about potential safety risks on the unit, such as disruptive patients or family members. At Texas Health Presbyterian, these check-ins are brief, lasting only two to three minutes unless there's an issue that needs more time.

The second component of this practice is to equip security personnel to prioritize areas of concern. Security personnel more frequently patrol units where staff have flagged potential safety concerns and adjust patrols throughout their shift as new issues arise or ongoing issues are resolved.

The third component of this practice is to hardwire knowledge transfer at shift change. Security personnel record key details from their check-ins with staff—including location, nature of threat, and contact person on the unit—and pass on this information to on-coming security personnel at the end of shift.

Three Key Components of Security-Driven Unit Rounding

Formalize check-in between security personnel and unit staff during regular patrols



Equip security personnel to prioritize areas of concern in ongoing patrols



Hardwire knowledge transfer at security shift change



Rounding Tool Prompts High-Value Interactions

To maximize the value of this practice, security personnel at Texas Health Presbyterian uses a tool like the one shown here during their patrols. Security personnel track unit-specific concerns on this tool to help monitor immediate and ongoing concerns. In addition, security personnel share this tool with on-coming personnel at change of shift to ensure knowledge transfer between shifts.

The following page details another organization's approach to tracking and sharing unit-level safety information.

Sample Security Rounding Tool

Officer: Karl Whitemarsh Date: 8-14-18

Area surveyed: 2A West, 2A East, Floors 3, and 4

Supervisor: Anne Herleth

For all units, check-in with the nursing station. Introduce yourself, duration of shift, purpose on unit.

List all unit-specific security vulnerabilities below (brief descriptions, room #, name of staff reporting issue):

	Room	Description	Notes	Staff	Unit Leader
Unit 2A West	204	Verbally disruptive pt.	Recommend room check every hour	Jessica L.	Maddie Langr Charge
Unit 2A East	232	Aggressive family member visiting	Spoke with family member directly; has been warned about behavior	Marisa D.	Marg Lucea NUM

Prompts security to make introduction and initiate check-in with staff at nursing station

Flags unit-specific concerns for immediate and ongoing follow-up

▶ To access the Nursing Executive Center's ready-to-use rounding tool, visit advisory.com/nec/resilience

Michael Garron's Approach to Security-Driven Unit Rounding

Similar to Texas Health Presbyterian, security personnel at Michael Garron Hospital, a 400-bed community hospital in Toronto, Ontario, Canada, check in with unit staff during their patrols. Rather than using a rounding tool, security personnel complete a computer-based report, called a pass-on log, at the end of the shift. Important information included in the pass-on log is shown here.







At Michael Garron Hospital, the pass-on log is shared with all security personnel, clinical leaders, and other key staff. This enables security personnel and other leaders to proactively intervene, or round more frequently near areas of concern.



Information Included in Pass-On Log

- Number of calls for service
- Number of reported incidents
- Location and description of incidents
- Staff involved in incidents
- Duration of patient watch, if conducted
- Location and description of high-risk patients

Staff Who Receive Completed Pass-On Log at Each Shift Change

 Privacy officer	 Occupational health and safety team
 Chief nursing officer	 Maintenance team
 Risk management team	 Director of support services

Make the Case for Security Rounding

If you are interested in implementing Security-Driven Unit Rounding, use the sample talking points shown here to introduce this practice to directors of security and other security personnel.

Sample Leadership Talking Points to Help Gain Security Buy-In

- 1. Your role is critical to keeping our staff and patients safe. But, that's increasingly difficult.**
 - There is an increase in the rate of violence in hospitals, including physical and verbal assault.
 - On top of that, it's impossible to have eyes and ears everywhere on campus. You have a lot of ground to cover and limited personnel to do it, so it's tough to always know what's going on.

- 2. Security-driven unit rounding uses a simple tool to augment your current patrols.**
 - Security-driven unit rounding is a best practice for patrols. It emphasizes security-clinician interactions and identifying potential safety concerns in collaboration before they happen.
 - To help do this, there is a rounding tool, which is similar to a security checklist. This tool reminds you to check in with clinicians and gives you room to document potential safety issues, such as an agitated patient.

- 3. This new approach will help keep you better informed and make it easier to do your job.**
 - Rounding will help make your job easier. Potential safety issues will already be on your radar and clinicians will take an active role in keeping you up-to-date.
 - Ultimately, this keeps our patients and staff safer.

▶ To access the Nursing Executive Center's full list of talking points, visit advisory.com/nec/resilience

Practice 3: Frontline De-escalation Team

Practice in Brief

Embed a rapid response team of trained clinical and non-clinical staff who can immediately respond to escalating behavior. The goal is provide in-the-moment support to frontline staff when patients or family members have escalating behavior.

Rationale

Occasionally, patients or family members become agitated, disruptive, or aggressive. As a result, the personal safety of frontline staff is at risk. By embedding trained experts who have the skills to safely de-escalate disruptive behaviors, you can reduce the response time to point-of-care safety threats to frontline staff.

Implementation Components

Component 1: Build a de-escalation team using upskilled frontline staff

Create a rapid response team for patients or family members with escalating behavior, which includes the following roles: a team lead, staff responders, and at least one security personnel. The staff responders are frontline clinical and non-clinical staff and are trained in advanced de-escalation techniques and safe restraint use.

Component 2: Give each member of the team a clear role during a de-escalation response

Provide each team member with a clear responsibility during an intervention, such as leading the de-escalation, attending to clinical needs, and administering medications when needed.

Component 3: Ensure sufficient number of staff responders on every shift

Track the number of frontline responders during every shift to ensure at least four responders are available at any time. If needed, train more frontline responders who work during hard-to-cover shifts, such as nights and weekends.

Practice Assessment

This practice requires up-front investment to train frontline responders and moderate ongoing administrative support to ensure the team is fully staffed 24/7. However, this practice provides three safety benefits: a quicker response time to escalating patients or family members, skilled responders who are confident in de-escalation techniques, and improved safety for frontline staff, responders, and patients.

Nursing Executive Center Grades:

Practice Impact: A

Ease of Implementation: B-

Acknowledge the Limitations of Security Personnel

Most organizations rely heavily on security personnel when patients or family members become agitated, disruptive, or aggressive. However, security personnel have limitations when responding to point-of-care violence, as detailed here.

First, there are a limited number of security personnel available to respond to a unit. An average 200- to 299-bed facility has 11 to 15 security personnel. However, this includes all security department staff, such as directors and others that are working in a back office.

Second, security personnel are limited in their ability to manage interactions with patients. While security personnel can assist in behavioral management, only clinical staff can administer chemical restraints or provide medical interventions when appropriate.



Limited Security Personnel

11–15

Median number of security department employees in hospitals with 200-299 beds¹

International Association for Healthcare Security and Safety

When security **assists** in the hands-on restraint or seclusion of a patient within the facility, there will be **continuous presence, direction, monitoring, and supervision of security actions by qualified facility clinical care staff.**

Security's Limited Role in Patient Behavior Management

! Physical Restraints
■ Can only assist with physical restraints

! Chemical Restraints
■ Cannot administer chemical restraints

! Clinical Interventions
■ Cannot medically intervene if patient condition declines

Valley Hospital, a 451-bed not-for-profit hospital in Bergen County, New Jersey, embedded a rapid response team comprised of trained clinical and non-clinical staff to provide in-the-moment support to staff when patients or family members have escalating behavior. The key components of this practice are described on the following page.

Source: Burmahl B, Hoppszallern S, "2012 Hospital Security Survey," *Health Facilities Management*, 2012, https://www.hfmmagazine.com/ext/resources/nc-hfm/pdfs/2012/HFM1012pSecurity_HFM.pdf; "Security Role in Patient Management," International Association for Healthcare Security and Safety, 2016, https://www.jointcommission.org/assets/1/6/05_02_Security_Role_Patient_Management.pdf; Valley Health System System, Ridgewood, NJ; Nursing Executive Center interviews and analysis.

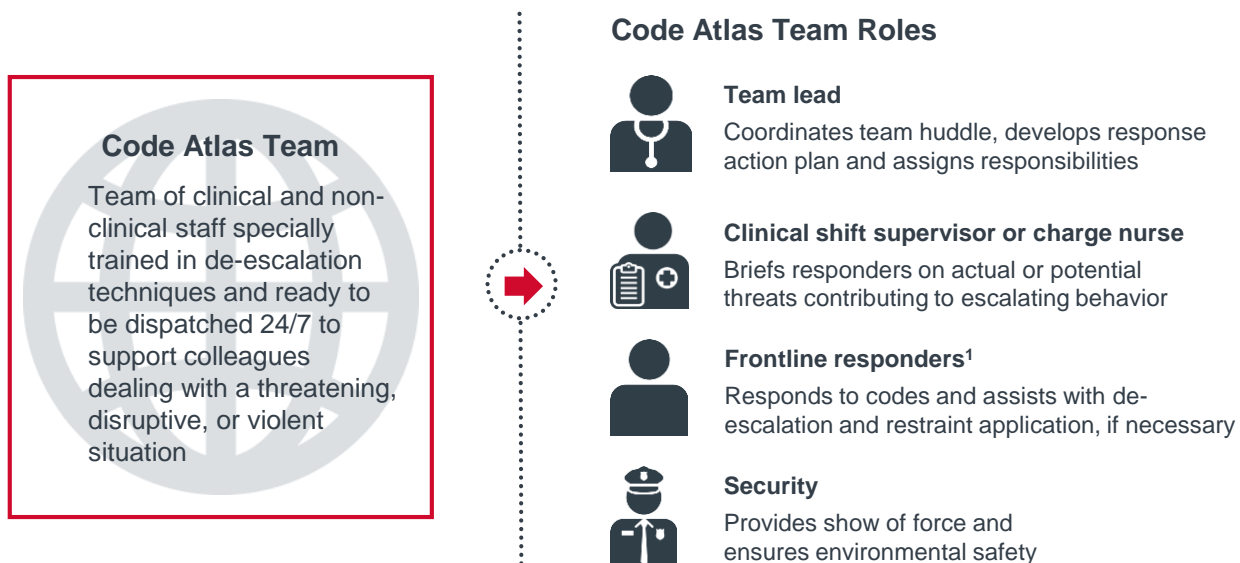
1) 28% of hospitals with 200-299 beds have 11-15 security department employees.

Embed Responders at the Front Line

Component 1: Build a de-escalation team using upskilled frontline staff

The first component of this practice is to create a rapid response team for patients or family members with escalating behavior. The team should include the following roles: one team lead, staff responders, and at least one security personnel.

At Valley Hospital, this rapid response team is called “Code Atlas.” Brief descriptions of team roles are described below. While all roles are important, the frontline staff responders are critical to the team’s success. Frontline staff responders are clinical and non-clinical staff who volunteer and are specially trained in advanced de-escalation techniques. By providing specialized training frontline staff, Valley Hospital can embed de-escalation experts on the front line. The next page provides more details on how Valley Hospital trains the frontline staff responders.



1) Participation in the “Code Atlas” Team is open to all staff at Valley Health Hospital, both clinically and non-clinically trained.

Source: Valley Health System, Ridgewood, NJ; Nursing Executive Center interviews and analysis.

Provide Robust Training for Frontline Team

Valley Hospital used a cost-effective approach to train frontline staff responders to safely manage escalating behavior. Leaders partnered with local experts at a psychiatric facility to provide specialized eight-hour training that includes advanced verbal and physical de-escalation techniques and safe physical restraint techniques. Each year, responders complete a recertification course. By contracting with an expert in the community, Valley Hospital received high-quality training at a low cost.

Valley Hospital's Three-Pronged Approach to Developing a Customized Training



Partnered with community expert

De-escalation training conducted by experts from local psychiatric hospital



Focused on advanced de-escalation

Eight hour training heavily focused on de-escalation techniques; secondary focus on safe restraint techniques



Required annual recertification

Recertification required for all de-escalation staff and offered twice annually

Costs for De-escalation Training at Valley Hospital

\$100

Cost per person for initial training

\$10,000

Total training costs for first year

\$5,000

Additional training costs after first year

“Code Atlas” in Action

Component 2: Give each member of the team a clear role during a de-escalation response

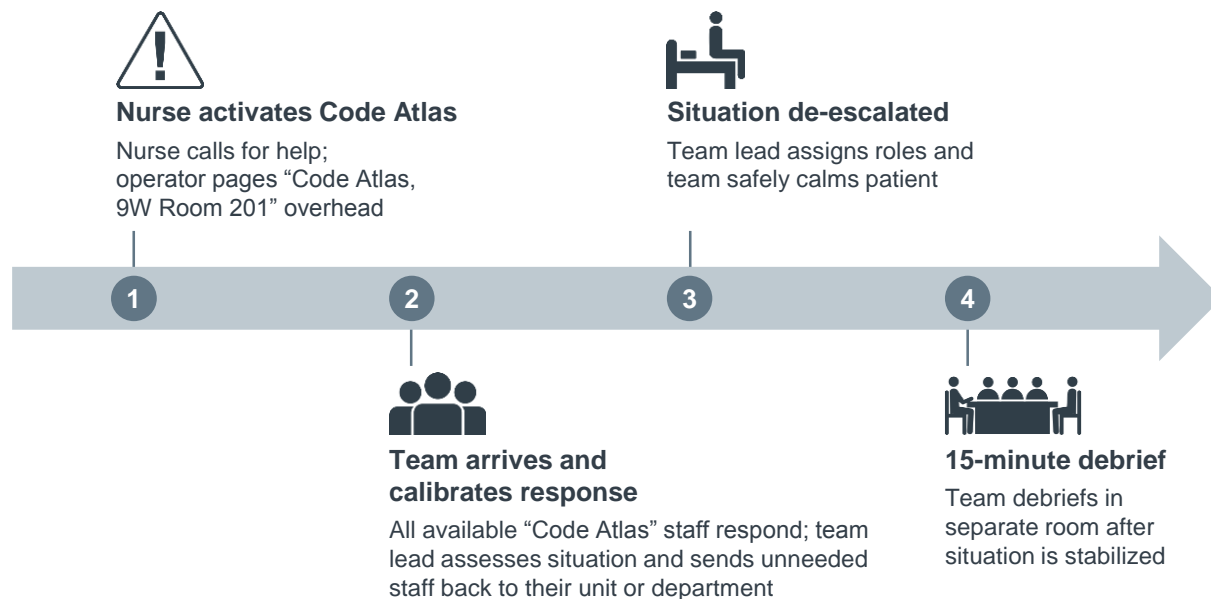
The second component of this practice is to provide each team member with clear responsibilities during an intervention, such as leading the de-escalation, attending to clinical needs, and administering medications when needed.

At Valley Hospital, team members have a clear role during each step of the de-escalation process. To do this, leaders developed a Code Atlas protocol, which includes the steps and roles of an intervention. An example of a Code Atlas response is described here.

When Code Atlas is activated, all available members of the Code Atlas team respond immediately. This includes all trained frontline staff responders on shift—typically four responders. However, if the frontline staff responder has a clinical role and is with a patient, then they prioritize the patient care they are currently providing and do not respond.

Next, the team lead determines how many frontline responders are needed. For example, if the patient is an 84-year-old woman with delirium whose intervention requires minimal support, the team lead will send almost all staff responders back to their usual work. Then, the team lead develops an action plan and assigns de-escalation responsibilities, with frontline staff responders often leading de-escalation.

Representative De-escalation Process



Post-intervention Debriefs Foster Continuous Improvement

Following every intervention, the team debriefs to discuss process improvement, using the questions shown here.

Valley Hospital's Debrief Questions

- 1 Was the response to the Code Atlas timely?
- 2 Were decisions made in a timely manner?
- 3 Was communication effective?
- 4 Were enough frontline staff responders present?
- 5 Could the escalation have been prevented?
- 6 What worked well?
- 7 What could have been improved?

▶ To access Valley Hospital's Code Atlas protocol and additional related resources, visit advisory.com/nec/resilience

Ensure a Full Team on Every Shift

Component 3: Ensure sufficient number of staff responders on every shift

The third component of this practice is to track the number of frontline staff responders during every shift to ensure at least four staff responders are available at any time.

Leaders at Valley Hospital shared how they ensured the target number of staff responders per shift. They also recommend regularly recruiting and training frontline staff responders who work during hard-to-cover shifts, such as nights and weekends.

How to Ensure Target Number of Trained Staff per Shift



Have a robust pool of trained staff

Train enough staff across the organization to account for all schedules. Valley Hospital trained 100 staff members in year one.



Recruit staff in all roles

Train staff from all departments, including non-clinical roles. Look for staff with predictable schedules.



Tag and track scheduled staff in staffing system

Tag trained staff in staffing system to allow for easy access staffing reports house-wide, by department. Track when trained staff are working and look for holes during certain shifts, such as nights or weekends.

Benefits of Wearable Tags Outweigh the Costs

Valley Hospital enacted an additional security measure for emergency department staff, who are exposed to point-of-care violence more often than other staff. ED staff have the option to wear geo-tracking tags that can be easily and discreetly activated when needed. These “personal panic buttons” activate a silent alarm, alerting a dispatcher of their exact location—including which room a staff member is in when calling for help.

At Valley Hospital, the avoided costs outweighed the financial investment required for the wearable tag system, as shown here.

Benefits of Geo-Tracking Wearable Alert Tags

✓	Easy, discrete activation anywhere
✓	Real-time locating system pinpoints and tracks staff's location
✓	Improved staff perception of safety
✓	Cost-effective when compared to a wired panic alert system

Expenses and Avoidable Costs Associated with Wearable Alert Tags in the ED

Line Item	Amount
System installation & training fees	\$28,000
Alert tags	\$17,500
Total alert tag expenses¹	\$45,500
ED-related lawsuits	\$600,000
Cost of lost employee days in ED	\$320,000
Total avoided costs²	\$920,000

1) Expense estimates courtesy of Stanley Healthcare and assumes purchase of 100 alert tags. Annual maintenance and support is 20% of software purchase price.

2) Avoided costs provided by Valley Hospital, based on estimates from two workers' compensation lawsuits in 2011 and 2013 respectively.

Source: Valley Health System, Ridgewood, NJ; Nursing Executive Center interviews and analysis.

“Code Atlas” Improves Staff Perception of Safety

Embedding a team with frontline staff responders reduces the response time to point-of-care safety threats.

At Valley Hospital, staff perception of safety increased after implementing the Frontline De-escalation Team. In addition, injuries from workplace violence decreased by 36% in three years, leading to cost savings in the workers' compensation budget.

Staff Survey Results on Perception of Safety in the ED

"I feel that workplace safety is taken seriously in my department"

70%

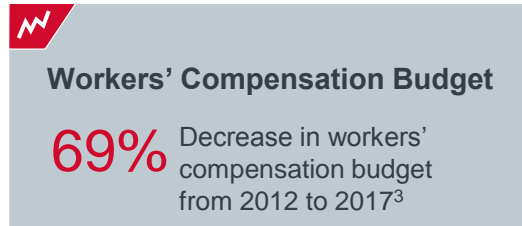
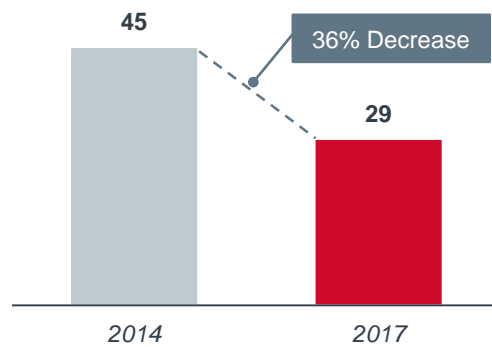
Increase from 2015 to 2016¹

"I feel that I can easily contact security if help is needed anywhere in the department"

76%

Increase from 2015 to 2016²

Cases of Workplace Violence Injuries



1) Survey driver increased from 50% to 85%.

2) Survey driver increased from 50% to 88%.

3) In 2011, Valley Hospital's workers' compensation budget was \$2.1 million.

Source: Valley Health System, Ridgewood, NJ; Nursing Executive Center interviews and analysis.

Practice 4: Behavioral Health Emergency Response Team

Practice in Brief

Create a rapid response team, made up of staff with behavioral health and de-escalation expertise, to manage all escalating patients in acute psychiatric crisis across the organization. The goal is to provide in-the-moment support to frontline staff who do not have behavioral health clinical expertise.

Rationale

The number of patients admitted with at least one behavioral health need is increasing. Yet many organizations do not have in-house resources to help frontline staff manage a patient in an acute psychiatric crisis. By creating a Behavioral Health Emergency Response Team, you can ensure behavioral health experts skilled in de-escalation are readily available to respond and help improve the safety of both staff and patients.

Implementation Options

Option 1: Leverage the inpatient psychiatric unit to create a behavioral health emergency response team

Create a rapid response team of clinical staff from the inpatient psychiatric unit who are trained in advanced de-escalation techniques.

Option 2: Build a behavioral health response team by training select care team members on key competencies

Create a rapid response team for escalating behavioral health patients by providing specialized training in behavioral health competencies and advanced de-escalation techniques to select frontline clinical staff.

Practice Assessment

This practice has two options for implementation. To select the best option for your organization, consider the behavioral health resources available in-house. If your organization has an inpatient psychiatric unit, select option one. If your organization does not have an inpatient psychiatric unit, select option two. Either option will have an outsized impact on the safety of staff and behavioral health patients.

Nursing Executive Center Grades:

Practice Impact: A

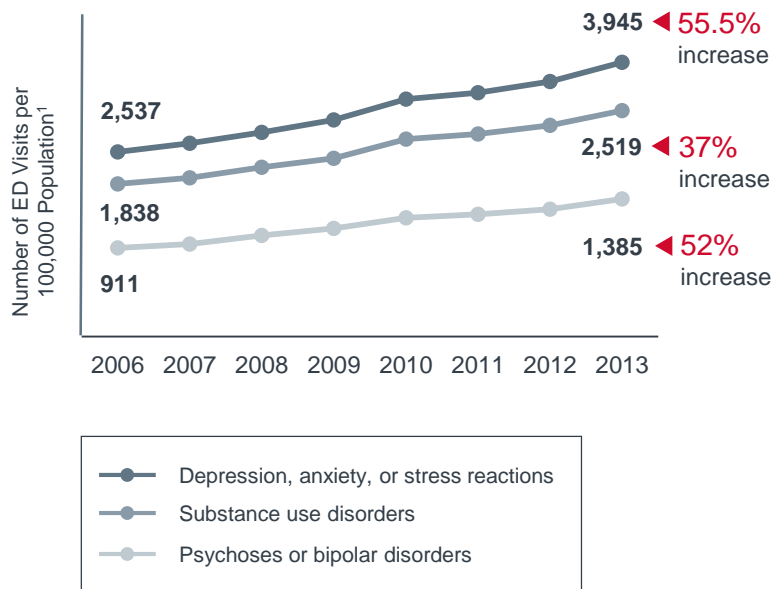
Ease of Implementation: B-

Upsurge in Behavioral Health Patients in Acute Care

The number of patients admitted to acute care with at least one behavioral health need is increasing, as shown below. However, there are a limited number of frontline staff with behavioral health clinical expertise. So, when a patient is in acute psychiatric crisis, frontline staff are often waiting too long for an expert to safely de-escalate the patient.

Rates of Emergency Department Visits Involving Mental and Substance Use Disorders

2006–2013



33%
Of adults have comorbid behavioral health and medical conditions

5 million
Number of ED visits in the U.S. with mental health as a primary diagnosis

13%
Reduction in state psychiatric hospital beds from 2010 to 2016²

To provide in-the-moment support to frontline staff who do not have behavioral health clinical expertise, organizations can create a Behavioral Health Emergency Response Team.

Source: Weiss AJ, et al., "Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006–2013," *Agency for Healthcare Research and Quality, HCUP Statistical Brief 216*, 2016, <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-VisitTrends.pdf>; 2011 Behavioral Health Services Strategy, Market Innovation Center, The Advisory Board Company; Ollive M, "Amid shortage of psychiatric beds, mentally ill face long waits for treatment," *PBS News Hour*, August 2, 2016, <https://www.pbs.org/newshour/nation/amid-shortage-psychiatric-beds-mentally-ill-face-long-waits-treatment>; Rui P, Kang K, "National Hospital Ambulatory Medical Care Survey: 2014 Emergency Department Summary Tables," Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2014_ed_web_tables.pdf; Nursing Executive Center interviews and analysis.

1) Aged 15 years and older.

2) In 2010 there were 43,318 state psychiatric hospital beds. In 2016, there were 37,679.

A Different-in-Kind Response Team

A Behavioral Health Emergency Response Team is a rapid-response team made up of staff with behavioral health (BH) and de-escalation expertise. The team manages all escalating patients in acute psychiatric crisis across the organization. Key components of the team are outlined below.

Behavioral Health Emergency Response Team (BERT)

- 1** Rapid response by clinicians with behavioral health expertise
- 2** In-the-moment de-escalation approach tailored for BH patients
- 3** Optimization of patient's care plan to avoid repeat escalations
- 4** Post-code debriefing focused on process improvement

Sample Behavioral Health Conditions Supported by BERT

- Psychotic episode
- Anxiety
- Post-traumatic stress disorder
- Depression
- Schizophrenia
- Dementia
- Agitated delirium
- Addiction
- Traumatic brain injury

Behavioral Health Emergency Response Teams often rely on clinical experts from inpatient psychiatric units. However, many organizations do not have inpatient psychiatric units or other on-site behavioral health experts. Therefore, this practice has two options. The first option requires an inpatient psychiatric unit in your facility; the second option does not.

Building a Behavioral Health Emergency Response Team

Option 1: Leverage the inpatient psychiatric unit to create a behavioral health emergency response team

The first option for implementing a Behavioral Health Emergency Response Team is to create a rapid response team of clinical staff from your inpatient psychiatric unit. Team members would be trained in advanced de-escalation techniques.

Mission Hospital, in Asheville, North Carolina, developed their Behavioral Health Emergency Response Team by using clinical experts from their inpatient psychiatric unit, as shown here. The team is led by a psychiatric clinician, typically a physician, and supported by a charge nurse or house supervisor. While the team members already have behavioral health expertise, they are specially trained in de-escalation techniques.

Option 2: Build a behavioral health response team by training select care team members on key competencies

The second option is to create a rapid response team by providing specialized training in behavioral health competencies and advanced de-escalation techniques to select frontline clinical staff. This option is for institutions without an inpatient psychiatric unit.

Froedtert Hospital developed their Behavioral Health Emergency Response Team without in-house psychiatric resources. As shown below, Froedtert Hospital's team has the same roles as the team at Mission Hospital. However, Froedtert Hospital's team is led by a nurse who is specially trained in behavioral health competencies and advanced de-escalation techniques. The details of that training are on the next page.

Comparison of Mission Hospital's and Froedtert Hospital's Behavioral Response Teams

	Mission Hospital	Froedtert Hospital
Organization in brief	<ul style="list-style-type: none"> • 760-bed hospital • Part of Mission Health's seven-hospital system • Asheville, North Carolina 	<ul style="list-style-type: none"> • 585-bed academic medical center • Part of Froedtert & The Medical College of Wisconsin, a three-hospital regional health system • Milwaukee, Wisconsin
In-patient psych unit?	Yes	No
BERT Team Lead	Psych intake clinician	Rapid response team nurse
BERT Facilitator	House supervisor or behavioral health unit's charge nurse	Charge nurse or senior administrator ¹
BERT Security	Security (minimum 2)	Security (minimum 2)
Training	<ul style="list-style-type: none"> • De-escalation training • Mock drill scenarios 	<ul style="list-style-type: none"> • Behavioral health overview • De-escalation training • Simulation center scenarios

1) During off hours, administrative supervisor replaces the charge nurse on the behavioral health emergency response team.

Source: Mission Health, Asheville, NC; Froedtert & The Medical College of Wisconsin, Froedtert Hospital, Milwaukee, WI; Nursing Executive Center interviews and analysis.

Provide Behavioral Health Response Training

They key components of Froedtert Hospital's training are shown here.

Leaders started by building clinical expertise in behavioral health. This competency training focused on recognizing symptoms and key patterns of behavior, as well as appropriate responses for behavioral health patients in crises.

Then, they provided two types of de-escalation training: a verbal de-escalation technique taught by a retired police officer and a de-escalation training through the Crisis Prevention Institute, an internationally recognized de-escalation training vendor.

Before launching the team, the team also practiced their training in a simulation lab using four common scenarios: delirium, substance abuse, acute psychosis, and admitted psychiatric patient. By investing in this training, Froedtert Hospital set their Behavioral Health Emergency Response Team up for success.

Components of Froedtert's Training for BERT Members



Behavioral health overview

Taught by in-house senior physician with clinical expertise in behavioral health



"Verbal judo"

Verbal de-escalation course taught by local retired police officer



De-escalation training

Advanced verbal and physical de-escalation course through Crisis Prevention Institute



Full-team simulation scenarios

Topics include delirium, substance abuse, acute psychosis, admitted psychiatric patient

▶ To access Behavioral Health Emergency Response Team resources from Mission and Froedtert Hospitals, visit advisory.com/nec/resilience

Improve Patient Care for a Unique Population

A Behavioral Health Emergency Response Team provides better care for behavioral health patients by tailoring a security response to the needs of the population.

At Froedtert Hospital, the team also takes steps to prevent future behavior escalation. One hour after a BERT response, a clinical nurse specialist rounds on the patient, checking for environmental irritants and completing a full clinical review, looking for ways to improve the patient's care plan.

How BERT Provides Better Care for Behavioral Health Patients



Provides tailored de-escalation

Team uses advanced psychiatric techniques to defuse mental health crisis.



Removes environmental irritants

Team audits the room and reduces or removes environmental irritants, such as loud TVs.



Reviews medication and care plan

Clinical nurse specialist rounds on patient, administers or adjusts medication and care plan as needed.



Uses restraints only as last resort

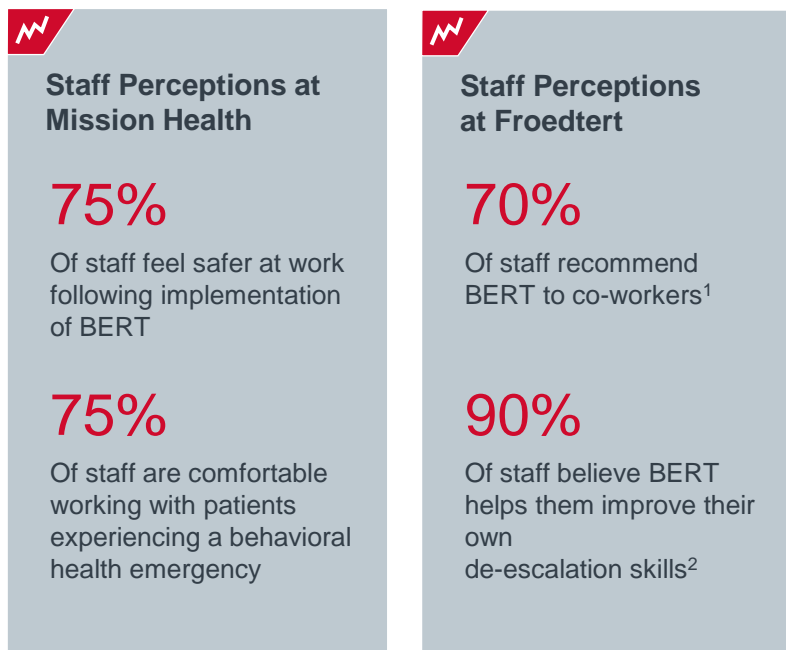
Team resorts to physical or pharmacological restraints as last resort. They are trained in safe application and administration techniques.

▶ To access the Froedtert clinical nurse specialist follow-up Epic template, visit advisory.com/nec/resilience

Staff Feel Safer with a Behavioral Health Response Team

The Behavioral Health Emergency Response Team reduces response time to point-of-care safety threats from patients in acute psychiatric crisis by ensuring there are trained experts available when needed.

Since implementing their teams, staff at Mission Hospital and Froedtert Hospital report feeling safer. In addition, Mission Hospital has seen reduction in workplace violence injuries as well as lost employee days due to workplace violence.



1) 70% of staff "strongly agree" with following statement: "I would utilize the Code Orange Behavioral Emergency Response Team (BERT) again and recommend it to my co-workers."
2) 40% of staff "strongly agree" and 50% "agree" with following statement: "By observing the Code Orange Behavioral Emergency Response Team (BERT), my skills at de-escalating are improving."

Source: Mission Health, Asheville, NC; Froedtert & The Medical College of Wisconsin, Froedtert Hospital, Milwaukee, WI; Nursing Executive Center interviews and analysis.

▶ Surface and Address Perceptions of Unsafe Staffing

- Practice 5: Staffing Assumptions Leadership Exercise
- Practice 6: Frontline Moral Distress Consult

Nurses Feel They Have to Make Compromises in Care

The second foundational crack undermining resilience 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. Any compromise on this commitment may cause nurses to experience moral distress, which is defined here. The impact of moral distress can be profound. In one study, one in five nurses reported an intent to leave their role because of moral distress.

Moral Distress

“When one knows the right thing to do, but **institutional constraints** make it nearly impossible to pursue the right course of action.”

*Andrew Jameton, 1984
American Philosopher*



20%

Of surveyed nurses indicated their intent to leave their current role due to moral distress¹

To make progress on this foundational crack, leaders must understand why nurses feel they have to make compromises in care delivery. One potential root cause is insufficient staffing. For organizations looking for strategies to ensure safe and appropriate staffing levels, we have listed several resources on the following page.

Source: Jameton A, *Nursing Practice: The Ethical Issues*, Englewood Cliffs: Prentice-Hall, 1984, pg. 6; Monash Business School's Australian Consortium for Research on Employment and Work, "What Nurses & Midwives Want: Findings from the National Survey on Workplace Climate and Well-Being," 2016, <https://www2.monash.edu/impact/articles/australian-nurses-and-midwives-contemplate-leaving-profession-as-workloads-bite-survey/>; Nursing Executive Center interviews and analysis.

1) A 2014 study of 395 nurses; data from a Moral Distress Scale-Revised survey.

Optimize Staffing to Ensure Safe and Appropriate Care

The Nursing Executive Center offers several resources to help all units and sites of care within your organization have safe and appropriate staffing levels.

The first resource, our 360-Degree Nurse Staffing Benchmarks, offers benchmarks for 19 types of acute care hospital units, as well as physician practices, ambulatory centers, and post-acute care organizations. This resource provides a unique data set quantifying trade-offs among staffing variables (including: nurse workload, education, specialty certification, and amount of support staff) within the same type of unit or ambulatory site.

The next two resources listed below are publications to help you build care teams that ensure all care team members are working at the top of their license.

The last two resources help reduce turnover with strategies, best practices, and tools for building a millennial-specific retention strategy for your organization.

Nursing Executive Center Resources on Staffing

Resource	Capsule Description
360-Degree Nurse Staffing Benchmarks	Database containing comparative staffing variables nurse leaders can use to structure care teams
Achieving Top-of-License Nursing Practice	Best practices for appropriately expanding nursing practice to meet the needs of increasingly complex patients
Building the High-Value Care Team	Strategies to help hospital leaders scale care team staffing to patient need
Win Millennial Loyalty	Millennial-specific retention strategies and best practices to supplement your engagement efforts.
First-Year Nurse Retention Toolkit	Three strategies to retain early tenure staff by promoting professional growth and building loyalty

▶ To access Nursing Executive Center staffing resources, search for them by name on [advisory.com](https://www.advisory.com)

Leaders must ensure every unit and care site has safe, appropriate, and cost-effective staffing levels. But even when staffing levels are appropriate, nurses can still feel they have to make compromises in care delivery. This solvable challenge is described on the next page.

Nurses Perceive That Staffing Levels Are Unsafe


The solvable challenge that leaders can address is that staff feel they can't deliver safe care to their patients because they perceive that staffing levels are "unsafe."

Based on Advisory Board's national engagement database, less than 36% of respondents agreed with the engagement driver, "My unit/department has enough staff." Moreover, when analysts ranked all 42 drivers based on performance, this driver was second to last compared to all other engagement drivers. Put another way, almost two-thirds of respondents feel that their unit or department doesn't have enough staff. At the same time, patient outcomes have improved in recent years, as shown below.

National Engagement Drivers Categorized by Rank¹

Rank by %	Engagement Driver	A/SA % ²
1	I know what is required to perform well in my job	89.2%
2	I have good personal relationships with coworkers in my unit/department	87.7%
3	My current job is a good match for my skills	85.5%
41	My unit/department has enough staff	35.9%
42	My organization helps me deal with stress and burnout	35.2%

Health Indicator Improvements, 2010-2014

 **17%**
Reduction in HAC³ rate (e.g. fewer adverse drug events, surgical site infections, etc.)

 **50K**
Total inpatient deaths avoided from HAC prevention

 **1.3M**
Total estimated reduction in HAC events

Unfortunately, staff often perceive that their unit or care site has an insufficient number of care team members even when staffing numbers are safe and appropriate and quality is not suffering. The executive strategy for addressing this challenge is on the next page.

1) N = 120,000+ registered nurses.
2) Agree/strongly agree percentage.
3) Hospital-acquired conditions; includes falls, catheter-associated urinary tract infections, pressure ulcers, adverse drug events, and other hospital-acquired conditions.

Source: Nursing Executive Center interviews and analysis.

Surface and Address Perceptions of Unsafe Staffing

The executive strategy is to uncover and then address what causes staff to perceive staffing levels to be unsafe. To do this, we recommend the two-step process shown here.

First, address any concerns managers have about staffing and reframe their perceptions as needed. The way a manager feels can strongly influence how staff feel about staffing. If managers have misperceptions about how their unit is staffed, they may unintentionally perpetuate misinformation.

Second, give frontline staff a formal channel for voicing their concerns. This enables you to reframe staff perceptions while also identifying trends and hot spots causing frontline moral distress.

The two practices in this section target each of these steps in turn.

Two Steps



Help unit leaders reevaluate their own staffing assumptions

Practice 5: Staffing assumptions leadership exercise

Give nurses a platform to disclose feelings of moral distress

Practice 6: Frontline moral distress consult

Practice 5: Staffing Assumptions Leadership Exercise

Practice in Brief

Facilitate a series of working sessions with unit managers to surface root causes of their own staffing misperceptions and build action plans to address them. The goal is for managers to understand the factors contributing to staff moral distress that are within their control to change.

Rationale

Managers often perceive that their units or care sites are short-staffed and feel powerless to address these issues. This can influence or reinforce frontline nurses' perceptions of staffing. When unit managers test their assumptions, identify root causes of staffing misperceptions, and address the root causes under their control, they can reduce staffing-related moral distress.

Implementation Components

Component 1: Provide a forum for managers to voice their concerns about staffing

Facilitate a working session for managers and other leaders to discuss staffing on their units. Managers discuss their perceptions as well as their own behaviors and practices related to staffing.

Component 2: Use data to help managers test their own assumptions

Share concrete data on number of FTEs per unit and any additional FTEs added in recent months, as well as trended data on staffing-related engagement drivers. Discuss these data with managers in contrast to their staffing-related perceptions.

Component 3: Brainstorm factors within managers' control to change

As a group, brainstorm a list of factors that can influence staffing levels or contribute to feeling understaffed. Determine which factors are under managers' control to change.

Component 4: Equip managers with action plan templates to address key root causes of staffing misperceptions

Provide managers with pre-made action-plan templates to address the top three to four themes identified behind staff perceptions of under-staffing. Managers may select more than one action plan if necessary.

Practice Assessment

This practice is an effective way to address staffing-related moral distress, especially when managers have misperceptions about the staffing levels on their units.

Nursing Executive Center Grades:

Practice Impact: A-

Ease of Implementation: B+

Uncover Managers' Assumptions

Component 1: Provide a forum for managers to voice their concerns about staffing

The first component of this practice is to gather managers together in a forum where they can voice their concerns about staffing on their unit or care site.

At Valley Children's Healthcare, a 358-bed pediatric hospital in the Central Valley of California, the Director of Workforce Engagement & Development used a monthly leadership meeting to facilitate an exercise examining staffing assumptions with charge nurses, managers, directors, vice presidents, and senior executives. During this forum, participants discussed the questions listed here in small groups, identifying situations when the managers and charge nurses felt short-staffed. Then, the facilitator used these situations to discuss the root causes of staffing issues and help leaders address those root causes that are under unit leadership control. Components 2 and 3 further explain how the facilitator did this.

Valley Children's Assumptions of Staffing Leadership Exercise

1 When was the last time your unit felt under-staffed?

Identify recent examples when your unit felt under-staffed. Collect details about the shift, including number of staff and patient census.

2 What variables may have contributed to feeling short-staffed?

List factors that may have contributed to the staffing challenges during that shift. Examples of other factors include staff calling in sick, overlapping PTO,¹ or non-top-of-license work.

3 Which staffing variables can you address directly?

Review the variables that may have contributed to staffing concerns and decide which are within your control. For example, approving PTO requests are within a leader's control.

1) Paid time off.

Reframe Managers' Perceptions

Component 2: Use data to help managers test their own assumptions

The second component of this practice is to use data to help nurse managers test their own assumptions and reframe their perceptions.

The leadership meeting facilitator at Valley Children's used unit-level data to help managers test their own assumptions. First, the group reviewed frontline nurse performance on the engagement driver, "My unit/department has enough staff," which performed poorly in nearly all units. Second, they reviewed current engagement survey results, measured after the organization meaningfully increased the number of full-time equivalents (FTEs) dedicated to patient care. Managers could see that adding FTEs did not improve frontline perceptions about staffing. In fact, they observed a further drop in staff perception on the engagement driver. As a result of this exercise, managers learned which of their own assumptions about appropriate staffing levels were true and which were false.

Valley Children's Process for Assessing Validity of Assumptions

1 Review past engagement data

Group reviewed last year's engagement data; only 44% positive response to staffing engagement driver¹

2 Examine changes to hospital FTEs

Leaders shared recent FTE additions, showing that 75% of new FTEs were dedicated to direct patient care

3 Assess current engagement data

Group examined current engagement data, which showed further decline in staffing engagement driver¹

There are several options for the types of data you can share with managers to help them test their own assumptions. Examples of helpful data are shown here.

Sample Data Useful for Testing Managers' Assumptions



Engagement Data

Trends in staffing-related drivers and overall engagement



Impact of Additional FTEs

Staffing numbers of new hires, including type and location



Staffing Benchmarks

Perspective on what is normative across similar units and care sites



Clinical Outcomes

Trended performance on key quality indicators

¹ Staffing driver: "My unit/department has enough staff".

Focus on Actionable Root Causes

Component 3: Brainstorm factors within managers' control to change

The third component of this practice is to brainstorm underlying reasons why a unit can feel under-staffed, even if has the appropriate number of FTEs.

Sample root causes are shown here. As a result of this exercise, facilitators at Valley Children's redirected conversations about staffing from the number of budgeted FTEs to factors that are within a managers' control to influence or change.

Managers and leaders at Valley Children's identified several ways managers can influence the factors identified during the session. Examples include having difficult conversations about chronic tardiness, backfilling for planned time off, holding staff accountable for attendance, and redistributing workload across the staff.

Root Causes of Unsafe Staffing Perceptions

- ▶ Poor attendance
- ▶ Calling out last minute
- ▶ Tardiness
- ▶ Too many people on PTO at once
- ▶ Lack of communication across shifts
- ▶ Voluntary turnover
- ▶ Seasonal census peak in the winter
- ▶ Lack of cross-training

Root Causes of Misperceptions Drive Action Plans

Component 4: Equip managers with action plan templates to address key root causes of staffing misperceptions

The fourth component of this practice is to equip managers with templates to make unit-specific action plans that address underlying root causes for staffing misperceptions.

Human resource leaders at Valley Children's identified three main themes from the list of root causes surfaced during the initial working session. The themes, detailed here, served as the foundation for action plan templates for unit managers to use.

If needed, dedicate one action plan to address a true need for FTEs. The action plan should help managers work with senior leaders to build a principled business case for additional staff.

Standardized Action Plans at Valley Children's



Maximize unit efficiency

Focuses on top-of license work by maximizing all staff skills and roles



Improve staff and leader accountability

Provides steps to hold staff accountable to job expectations, workload, and policy compliance



Build a business case for additional staff

Helps managers build a business case for additional FTEs

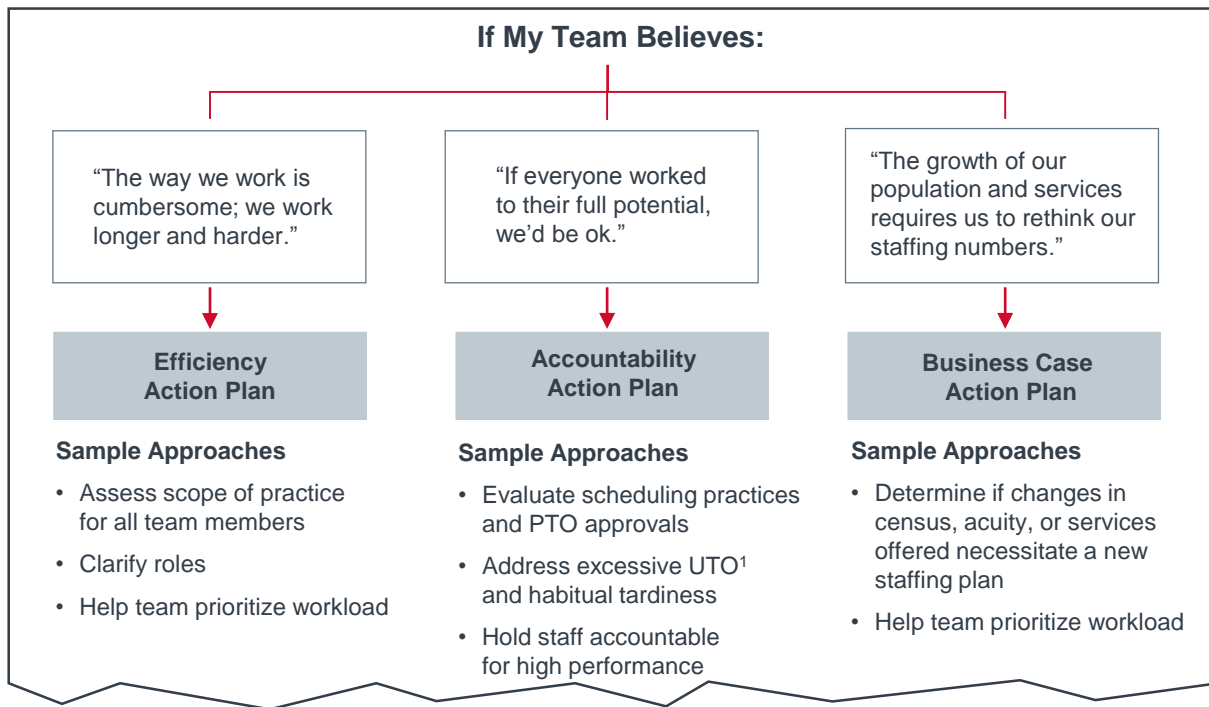
Help Leaders Select Best Action Plan

Managers may need help selecting the best action plan for their units. Valley Children’s human resource leaders developed the guidance shown here.

Managers tailor the templates for their units or care sites. If they identify multiple root causes, they can create more than one plan, while prioritizing most important action steps.

After managers at Valley Children’s build the action plans, they share them with their unit staff and engage them in the solutions.

Excerpt of Action Planning Selection Guide



► To access Valley Children Healthcare’s action planning selection guide, visit advisory.com/nec/resilience

1) Unscheduled time off.

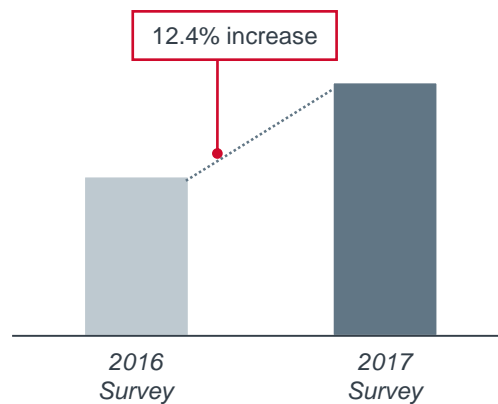
Source: Valley Children’s Healthcare, Madera, CA; Nursing Executive Center interviews and analysis.

Improving Frontline Perceptions About Staffing

Valley Children's staff engagement improved after managers implemented their unit-level action plans. Specifically, the engagement driver, "My unit/department has enough staff," improved by 12.4% in the 2017 staff engagement survey.

Valley Children's Engagement Results 2016-2017

*Percentage of Positive Survey Responses¹
to "My Unit/Department Has Enough Staff"*



1) "Agree" or "strongly agree."

Practice 6: Frontline Moral Distress Consult

Practice in Brief

Create a forum with an expert facilitator in which staff voice their concerns when they experience moral distress. The goal is to reduce frontline moral distress by helping staff identify the root causes of moral distress, correct any misperceptions, and discuss appropriate solutions.

Rationale

When frontline nurses perceive that their unit is short-staffed, they may experience moral distress. But nurses' perceptions of staffing levels aren't always accurate. By providing a formal channel for staff to discuss their moral distress, you can help them identify the root causes of their concerns and focus on solutions. Facilitators can also identify and elevate issues requiring house-wide intervention.

Implementation Components

Component 1: Establish an expert-led forum for staff to discuss moral distress

Establish a formal consult that staff can easily activate when they experience moral distress. The consult should be led by expert facilitators and may be conducted with staff one-on-one or as a group with other staff who have related concerns.

Component 2: Steer moral distress conversations toward solutions

Use the Frontline Moral Distress Consult to examine individual and unit-level factors contributing to moral distress, correct any misperceptions, and focus the conversation on appropriate solutions.

Component 3: Elevate systemic issues to organizational leaders

When appropriate, the facilitator should alert leaders about recurring themes or system-wide issues that require a broader organizational approach to resolve.

Practice Assessment

We recommend this practice for all organizations whose staff experience moral distress, despite safe staffing levels. It is an effective way to correct any frontline misperceptions about staffing and surface system-wide issues that may have otherwise been overlooked.

Nursing Executive Center Grades:

Practice Impact: B+

Ease of Implementation: B

Give Staff a Channel to Voice Concerns

Component 1: Establish an expert-led forum for staff to discuss moral distress

The first component of this practice is to develop an on-demand, facilitated forum for staff to discuss times when they feel moral distress.

Leaders at Children's Health, a 487-bed pediatric hospital in Dallas, Texas, developed a consult service that nurses can activate by calling a hotline. Trained facilitators lead a session—either one-one-one or with other staff involved—to discuss the concern that prompted the call. Unlike a crisis debrief service, the consult focuses on nurses' moral distress. The four primary goals of the Frontline Moral Distress Consult are listed here.

Key Goals of Frontline Moral Distress Consult



Provides a platform for staff to share concerns

Interdisciplinary discussion with peers mitigates internalization of distress.



Expands staff perceptions

Fact-driven approach helps staff understand the bigger picture.



Surfaces house-wide trends

Consults enable leadership to identify patterns of moral distress.



Facilitates staff-driven solutions

Staff identify solutions that address initial concerns.

Guidance for Finding the Right Facilitator

To ensure an effective facilitator leads the Frontline Moral Distress Consults, we recommend using the criteria detailed here. Facilitators should be skilled in group facilitation, trained in moral distress, trusted by the staff, and capable of challenging assumptions when necessary. Children's Health typically uses two facilitators per hour-long group session.

Key Characteristics of an Effective Facilitator

- ✓ **Skilled in communication and group facilitation**
Background or specific training in facilitation
- ✓ **Trained in clinical ethics**
Background in health care ethics with understanding of moral distress
- ✓ **Trusted among staff**
Respected reputation and trusted among staff
- ✓ **Capable of expanding perceptions**
Insightful in clarifying fact and fiction in highly charged situations

2 facilitators
Recommended to facilitate each consult

1 hour
Recommended duration of consult

Get Staff to Make the Call

To raise awareness of the Frontline Moral Distress Consult, leaders at Children’s Health used the communication channels described here-

The first two channels—unit-based education and ethics journal clubs—aimed to build awareness of moral distress and proactively prevent any stigma associated with activating the consults. The third channel is a multidisciplinary group of staff champions who participate in a 12-month training series focused on moral distress. They help raise awareness about the service and also serve as Frontline Moral Distress Consult facilitators.

Methods for Raising Awareness of Moral Distress at Children’s Health



Unit-based education

Teach staff to be aware of moral distress through educational sessions on various units



Ethics journal club

Raise awareness through bookclub-style discussions



Staff champions

Train select staff¹ across the organization to volunteer as ethics champions among their peers

1) Can include nurses, advanced practice clinicians, psychologists, social workers, chaplains, music therapists, and bereavement counselors.

Source: Children’s Health, Dallas, TX; Nursing Executive Center interviews and analysis.

Use Facts to Understand Moral Distress

Component 2: Steer moral distress conversations toward solutions

The second component of this practice is to examine the factors that influence moral distress and shift the conversations towards solutions.

In response to the activation call, facilitators at Children's Health organize an hour-long meeting within a week for staff to discuss the situation in more detail. The meetings follow the four-step process shown here.

First, facilitators at Children's Health establish confidentiality. They take note of the number of attendees, the disciplines represented, and the case issue, but they do not track names of attendees.

Second, participants share details of their experience. The nurse who called the Frontline Moral Distress Consult hotline shares their perspective. Remaining participants add details to provide more context.

Third, the group focuses on uncovering potential root causes for the moral distress. At Children's Health, facilitators encourage staff to challenge their own perceptions and uncover other underlying issues they may not have considered.

Fourth, they identify solutions and next steps for addressing the key issues identified.

Four Steps in the Assessment Process at Children's Health

- 1 Set ground rules**
Establish confidentiality and ask the group to remain open and respectful of different perspectives during the session.
- 2 Start with the facts**
Ask participants to share the facts surrounding the triggering incident.
- 3 Identify root causes of distress**
Guide group dialogue to identify organizational, department, unit, or team constraints causing moral distress.
- 4 Determine next steps**
Decide if additional steps are needed. Examples include supplemental consultations or seeking support resources through the Employee Assistance Program.

Elevate Broader Issues for House-Wide Action

Component 3: Elevate systemic issues to organizational leaders

The third component is to consolidate any system-wide themes in the root causes and bring them to the organizational leaders for potential house-wide action.

Frontline Moral Distress Consult facilitators surface recurring themes or issues requiring broader action. While protecting confidentiality, facilitators elevate these systemic issues to senior leaders who can address them as needed.

Identification and Elevation of Systemic Factors Contributing to Moral Distress



▶ Make Emotional Support Opt-Out Only

- Practice 7: Manager-Triggered Psychological First Aid
- Practice 8: Embedded Emotional Support Bundle

There Is No Time to Recover

The third foundational crack undermining nurse resilience is that staff bounce from traumatic experiences to other care activities with no time to recover. This is because clinicians have more to do in less time. For example, increased patient complexity and decreased length of stay means clinicians have more patient care activities to complete before discharge. Put simply, staff don't prioritize emotional well-being when they already feel stretched thin, which can negatively impact emotional well-being over time.

Factors Contributing to Reduced Clinician Recovery Time



More care activities

Higher patient complexity and acuity and more documentation means clinicians have more to do per patient



Increased patient turnover

Increased patient churn and decreased length of stay means clinicians care for more patients in less time

Leaders can't prevent trauma in the health care setting—it is part of the job. But there is a solvable challenge behind this issue, which is described on the next page.

Source: Mealer M, et al., "The prevalence and impact of post-traumatic stress disorder and burnout syndrome in nurses," *Depression and Anxiety*, 26, no. 12, 2009:1118-26, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2919801/>; Missouridou M, "Secondary Posttraumatic Stress and Nurses' Emotional Responses to Patient's Trauma," *Journal of Trauma Nursing*, 2017, 24(2):110-115, <https://www.ncbi.nlm.nih.gov/pubmed/28272184>; Nursing Executive Center interviews and analysis.

Nurses Don't Use Services That Can Help with Recovery

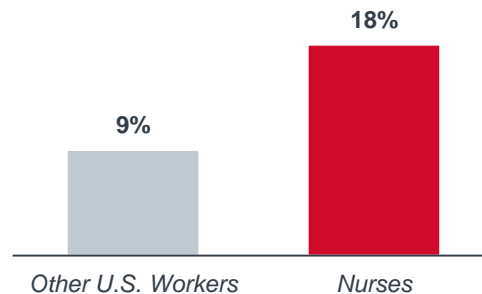
The solvable challenge that leaders can address is that nurses don't use services that can help them debrief, process, and recover from traumatic experiences.

For example, many organizations rely on Employee Assistance Programs (EAPs) or other work-based programs to provide emotional support to staff in need. However, EAP utilization is typically very low. As shown here, only 3% to 5% of nurses use their organization's EAP.

The effects of no recovery time and not using available services are shown here. In the United States, depression and anxiety rates among nurses are higher than other workforces. As a result, leaders need to rethink how they provide emotional support at their organization.



Rates of Depression in Other Workers Versus Nurses¹



1) n = 1,171 nurses.

Source: Carchietta GA, "Five steps to increasing utilization of your Employee Assistance Program," *Workplace Health and Safety*, 63, no. 3 (2015): 231, <https://www.ncbi.nlm.nih.gov/pubmed/25994979>; Nursing Executive Center interviews and analysis.

Make Emotional Support Opt-Out Only

The executive strategy is to make emotional support opt-out rather than opt-in. In other words, organizations need to bring emotional support directly to frontline staff so they don't have to seek it out.

Specifically, organizations should offer the two types of emotional support shown here as default services, rather than making staff have to seek them out. The first focuses on support immediately following a traumatic event. The second focuses on supporting nurses during times when routine stressors—such as changes in workflow or fluctuating census—are more acute than usual. The two practices in this section address each in turn.

Two Types of Emotional Support to Make Opt-Out Only



Immediately following traumatic event

For individuals who are involved in a traumatic event, including death, serious injury, threat, or violent attack



During times of high routine stress

For individuals or units experiencing a heavy load of daily workplace stressors

Practice 7: Manager-Triggered Psychological First Aid

Practice in Brief

Create a team of trained clinical and non-clinical staff who can provide on-unit, emotional support to frontline staff immediately following a traumatic incident and connect staff with ongoing support when needed. The goal is to ensure frontline staff receive emotional support to help them cope with traumatic incidents effectively.

Rationale

When nurses are exposed to traumatic incidents, they often feel too busy with patient care activities to take time to debrief and recover. By requesting psychological first aid responders on the unit, managers bring emotional support directly to staff immediately following a trauma—so staff don't have to seek it out on their own.

Implementation Components

Component 1: Create a team of trained psychological first aid responders

Recruit eligible clinical and non-clinical staff to serve on the psychological first aid team. Staff attend a training to learn how to provide psychological first aid and how to connect staff with additional support resources when needed.

Component 2: Activate psychological first aid for staff in need following a traumatic event

Upon manager or staff request, send psychological first aid responders following a traumatic event on a unit. Examples of a traumatic event include: an adverse patient outcome, patient death, and point-of-care violence. On-call responders arrive within one hour of the request and provide direct support to frontline staff individually or as a group, and stay on the unit as long as needed.

Component 3: Connect frontline staff with ongoing emotional support, as needed

Connect frontline staff with ongoing support as needed. Additional support may include: formal incident debriefing, counseling, or support through the Employee Assistance Program.

Practice Assessment

This practice requires upfront investment to train and compensate psychological first aid responders. However, Manager-Triggered Psychological First Aid is an effective practice to help prevent secondary trauma among frontline staff who are exposed to traumatic incidents during their daily work. The Nursing Executive Center recommends this practice to all organizations that do not have a trauma-response support system in place.

Nursing Executive Center Grades:

Practice Impact: A-
Ease of Implementation: B

Embed Just-in-Time Response to Trauma

Psychological first aid is a type of emotional support often used by disaster relief organizations. The goals are to reduce initial distress caused by trauma, enhance coping strategies, and actively connect individuals with ongoing support services. As shown here, psychological first aid can also be used following trauma in the health care setting.

Psychological First Aid

What It Is:	What It Is Not:
✓ Gathering information about the incident through active listening	✗ Critical incident debriefing
✓ Validating, acknowledging emotions	✗ Counseling
✓ Teaching coping strategies	✗ Psychotherapy
✓ Referring to ongoing emotional support services	✗ Mental health treatment

Sample Reasons to Use Psychological First Aid in Health Care

- Traumatic patient death
- Unexpected patient outcome
- Medical error with patient harm
- Point-of-care violence

Main Line Health, a five-hospital health system headquartered in Bryn Mawr, Pennsylvania, implemented psychological first aid to help support staff in the immediate hours following trauma. The key components of this practice are detailed on the following pages.

Building a Team of Trained Psychological First Responders

Component 1: Create a team of trained psychological first aid responders

The first component of this practice is to develop a team of trained responders who can provide psychological first aid to staff.

Main Line Health's approach to creating a team is shown here. Leaders recruit clinical and non-clinical staff to serve on their psychological first aid team. To qualify, staff must be skilled communicators and complete an in-house psychological first aid training. Training includes skill-building for communication and healthy coping strategies and program education such as scheduling requirements and how to refer staff to ongoing support services.

Psychological first aid responders at Main Line Health are compensated when they respond to a trauma. Hourly workers receive their hourly wage for the hours worked on the call, while salaried employees receive a \$150 stipend each time they respond to a call. Information on other costs associated with building a team of psychological first aid responders are listed on the next page.

Key Components of Main Line Health's Psychological First Aid Team



Staff recruitment

All clinical and non-clinical staff eligible; employed for at least 90 days and have a high communication score on most recent performance evaluation



Training

Team members complete day-long psychological first aid and resiliency training; annual four-hour refresher course required as well



Compensation

Hourly staff receive hourly wage; salaried staff receive a fixed rate per response



Team Economics

\$3,500

Cost per psychological first aid training course

\$10K

Total annual cost for psychological first aid team¹

1) Does not include cost of part-time team coordinator's salary and benefits.

Examining the Costs of Psychological First Aid

The pro forma shown here details annual team and training expenses for Main Line Health’s psychological first aid team.

Annual Expenses of Main Line Health’s Psychological First Aid Team

Line Item	Amount ¹
Psychological first aid training course	\$7,000 ² (2 classes)
Responder ID badges	\$500 (50 badges)
Pagers	\$960 ³
Printed materials and training handbooks	\$250
Responder compensation (hourly)	\$370 (10.5 response hours)
Responder compensation (fixed-rate)	\$1,500 (10 stipends) ⁴
Total Annual Expenses	\$10,580

1) Predicted expenses based on 150 members, 2 shifts per day x 2 teams per day x 365 days per year.

2) Training is offered 2-4 times annually, depending on recruitment needs.

3) This is a maximum cost, as not all responders will need a pager.

4) Hourly and fixed-rate compensation varies by year based on staff demand but is approximately \$2,000.

Source: Main Line Health, Bryn Mawr, PA; Nursing Executive Center interviews and analysis.

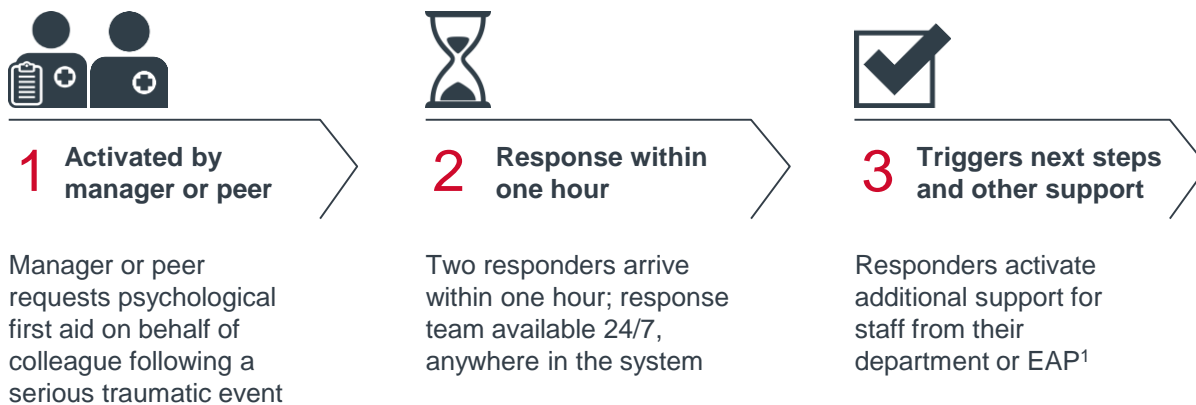
Bring Psychological First Aid Directly to Nurses

Component 2: Activate psychological first aid for staff in need following a traumatic event

The second component of this practice is to send psychological first aid responders to a unit following a traumatic event. Either the unit manager or staff can request the team by calling a central hotline.

At Main Line Health, two on-call psychological first aid responders arrive within one hour of the request and provide emotional support to staff as long as needed. Emotional support is provided one-on-one or as a group and includes: debriefing the incident, discussing emotions, and determining ongoing coping strategies. The unit manager, other nursing leaders, or peers cover staff members' patients while they receive psychological first aid. If needed, the psychological first aid responders recommend additional support for frontline staff, which is detailed on the next page.

Key Steps in Psychological First Aid Team's Response Process



1) Employee Assistance Program.

Leverage the Employee Assistance Program

Component 3: Connect frontline staff with ongoing emotional support, as needed

The third component of this practice is to connect frontline staff with ongoing support, as needed. Additional support may include: formal incident debriefing, counseling, or other support through the Employee Assistance Program.

The table shown here details how Main Line Health uses their EAP to provide ongoing support to staff and psychological first aid responders. Responders connect staff to the EAP by sharing informational materials or calling the program on the spot. This means staff in need of additional support services, such as counselling, don't have to access the EAP on their own.

Main Line Health also requires psychological first aid responders to connect directly with EAP within 72 hours of a trauma response. The goal is to prevent secondary trauma by debriefing with responders.

EAP Involvement in Psychological First Aid Response at Main Line Health

EAP Involvement	Individual Staff	Psychological First Aid Responders
Overview of the Program	Responder shares brochure about EAP services with staff member during initial psychological first aid interaction	All responders trained on EAP services during initial psychological first aid training
Activation of Services	Responder activates EAP services for staff member receiving psychological first aid	EAP stays on the line during Psychological first aid response to support the responder
Longer-Term Follow-Up	Initial activation of EAP triggers follow-up support for staff in need of more clinical services	Responders required to debrief with EAP within 72 hours of delivering psychological first aid

The next page provides more information on how first responders at Main Line Health document their interactions with staff.

Put Follow-Up Steps in Motion

Responders at Main Line Health use the form excerpted here to log incidents. They record key details of the incident, such as number of affected staff and type of incident. To protect confidentiality, responders do not record staff names. By ensuring anonymity, frontline staff are more likely to share emotions and use the psychological first aid team effectively.

This form also helps a team coordinator compile data about incidents. Main Line Health tracks incident type, frequency, and number of staff affected, then reports trends to senior leadership, as needed. For example, if the number of incidents of point-of-care violence increases in one unit, this trend is shared with senior leaders so they can address it.

Psychological First Aid Team's Follow-Up Form

*Facility:	Choose an item.
*Department:	Choose an item.
Incident type:	Choose an item.
Brief description of incident:	
*Estimated number of affected employees:	
REQUEST FOR CIRT RESPONSE	
Telephonic assessment by (name):	
*Date: Click here to enter a date.	*Time:
CIRT Response needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes:	
CIRT RESPONSE	
CIRT Responders: 1.	
2.	
Additional CIRT Responders:	
*Time CIRT arrived on scene:	
*Time CIRT Response ended:	
*Time spent on site (hours):	
*Number of employees met with:	
Common theme(s): <input type="checkbox"/> Anger <input type="checkbox"/> Fear <input type="checkbox"/> Chaos <input type="checkbox"/> Anxiety	
(check all that apply) <input type="checkbox"/> Helplessness <input type="checkbox"/> Hopelessness <input type="checkbox"/> Sadness	
<input type="checkbox"/> Grief <input type="checkbox"/> Other:	
ADDITIONAL INFORMATION	
Name of Manager:	
FirstCall contacted from the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, for CIRT Member? <input type="checkbox"/> Yes <input type="checkbox"/> No For distressed employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Departmental intentional follow-up recommended with FirstCall? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes:	
Unusual circumstances encountered:	
Suggestions for improvement:	
Completed by:	
Additional information:	

Responders briefly describe incident, including number of affected staff; staff names omitted to protect confidentiality

Responders suggest next steps, such as critical incident debriefing or EAP support

▶ To access Main Line Health's Psychological First Aid Team Response Form, visit advisory.com/nec/resilience

Improve Communication and Empower Staff

At Main Line Health, the psychological first aid team improved emotional support immediately following a traumatic incident.

The qualitative feedback shown below emphasizes the value of this program for managers as well as frontline staff. Unit managers are more aware of their staff's emotional state and have support to help them effectively cope.



Benefits of Psychological First Aid

- ↑ Increased immediate emotional support services
- ↑ Increased manager awareness of staff's emotional state
- ↑ Increased EAP utilization by staff and first responders

“

“The work we do is tough and sometimes takes us to our emotional limits. The [psychological first aid] program has created an **easily accessible avenue to provide immediate support and has proven to be a valued asset** in times of great distress.”

*Nurse Administrator,
Main Line Health*

“

“As a nurse leader, I feel the responsibility to support staff emotionally. [Following the traumatic event] I felt ill-prepared. The responders were quickly accessible that first day, for all shifts, and for several days afterward to help us process our feelings. **I feel so lucky to have this service available for a time like this.**”

*Nurse Educator,
Main Line Health*

Practice 8: Embedded Emotional Support Bundle

Practice in Brief

Create a bundle of emotional support resources that managers and frontline staff can easily activate for a team member in need. The goal is to provide frontline staff with multiple options to help manage work-related stress—even when they don't ask for help.

Rationale

There are many stressors in the health care environment. But frontline staff often don't have time to seek out existing emotional support resources at their organization. As a result, resources are under-utilized and staff become stressed and overwhelmed. By creating an Embedded Emotional Support Bundle, nursing leaders bring a variety of emotional support options directly to frontline staff—so staff have support when they need it.

Implementation Components

Component 1: Take inventory of existing emotional support resources

Identify emotional support resources currently available to frontline staff at your organization. Consult with HR and unit-level leaders as needed to build a list of organization-wide and unit-specific emotional support resources. Use the checklist on page 83 to help determine which resources are most effectively supporting staff.

Component 2: Create a bundle of effective, opt-out support resources

Identify a minimum of three emotional support resources to include in the Embedded Emotional Support Bundle—either by improving current resources or supplementing with new resources. Examples of effective resources include: manager-triggered psychological first aid (see page 73), on-unit counseling, and moments of silence.

Practice Assessment

The Nursing Executive Center recommends this practice for all organizations as an effective strategy to help frontline staff manage work-related stress. At minimum, leaders should evaluate their current emotional support resources and ensure that unit managers know what resources are available for their staff.

Nursing Executive Center Grades:

Practice Impact: B

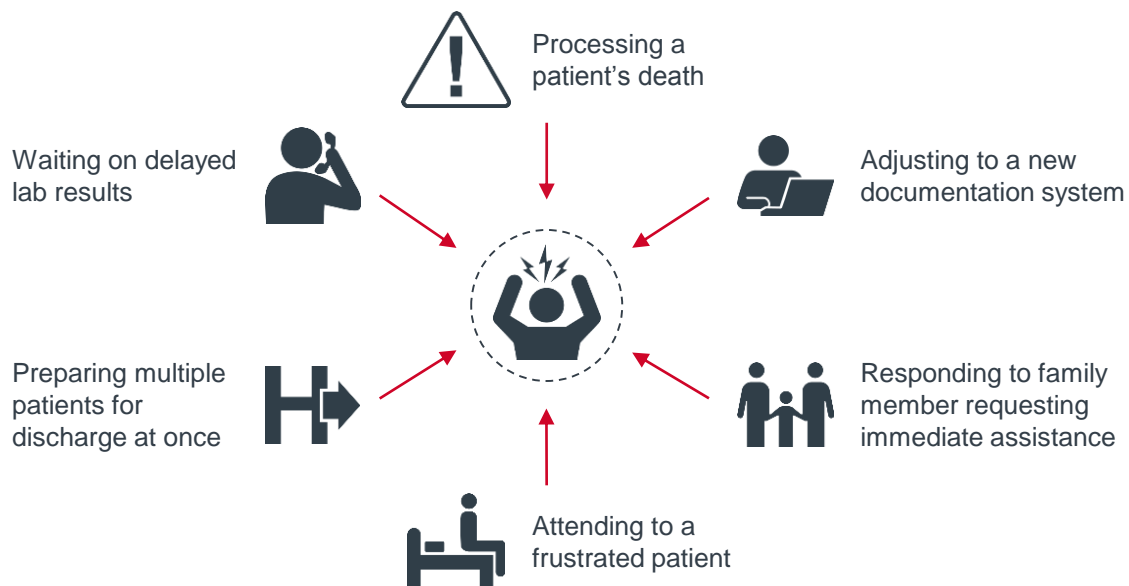
Ease of Implementation: A-

Emotional Stress Comes in All Shapes and Sizes

Frontline staff have many sources of stress in their day-to-day work environment, some examples of which are shown here. Individually, these situations may not be overwhelming, but together they can wear down even the most resilient nurse.

One way to help frontline staff better manage routine stress is to bring a variety of emotional support options directly to the front line—so staff have support when they need it. The key components of an Embedded Emotional Support Bundle are listed on the next few pages.

Representative Health Care Workplace Stressors



Emotional Support Resource Audit

Component 1: Take inventory of existing emotional support resources

The first component in this practice is to identify emotional support resources currently available to frontline staff at your organization. Consult with HR and unit-level leaders as needed to build a list of organization-wide and unit-specific emotional support resources.

After compiling a list of emotional support resources available, use the audit shown below to assess them. First, each resource should be opt-out only. Put another way, create systems that don't require frontline staff to seek out the support themselves, but instead requires them to opt-out if they choose not to accept it.

List current emotional support resource	Opt-out only?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Determine if the existing emotional support resources listed above meet the criteria shown below. Check all that apply. After completing this audit, use the information on the next page to build an Embedded Emotional Support Bundle.

<input type="checkbox"/> There are strategies accessible to staff working night and weekend shifts <input type="checkbox"/> There are strategies that address both serious trauma and routine stress <input type="checkbox"/> There is at least one strategy to help staff cope with a patient death <input type="checkbox"/> Staff can mix and match strategies to support their varying emotional needs <input type="checkbox"/> Managers have a go-to resource or person for questions about support

Build Your Emotional Support Bundle

Component 2: Create a bundle of effective, opt-out support resources

Identify a minimum of three emotional support resources to include in your Embedded Emotional Support Bundle—either by improving current resources listed on page 83 or supplementing the bundle with new resources. Examples of effective resources include: manager-triggered psychological first aid (see page 73), on-unit counseling, and moments of silence.

For additional Embedded Emotional Support Bundle ideas, consult the picklist shown here or keep reading. The following pages detail one organization’s approach to the Embedded Emotional Support Bundle.

Emotional Support Bundle Options

Bundle element	Capsule description	How it’s opt-out only	Potential impact
Chaplain-led recovery time	On-unit guided conversations between nurses and chaplains that are focused on managing routine daily stressors	Manager request, available on unit	
Vital hearts training	Three-day intensive training on resilience and compassion fatigue	Manager-initiated	
Bounce-back kits	Premade kits with reflection exercises on a range of themes, including acceptance, letting go, anger, gratitude, and rest	Manager or peer delivered	
Moments of silence	Guided meditation or a period of silence at specific times throughout the day	Manager-initiated	
Code Lavender	Nurse-driven holistic care rapid response serving patients and clinicians in need of intensive emotional or spiritual support	Manager request, available on unit	
Code Lavender carts	Carts with relaxation materials that are designed to help staff ground and center themselves during moments of heightened stress	Manager or peer delivered	
Relaxation trainings	Mindfulness, meditation, controlled breathing, journaling, and other teachable relaxation techniques	Manager recommended	
Quiet rooms	Private or semi-private room to give staff a break from workplace stress	Manager or peer suggested	

Low Impact

Moderate Impact

High Impact

Source: Advocate Children’s Hospital, Oak Lawn and Park Ridge, IL; Nursing Executive Center interviews and analysis.

Advocate Children's Hospital's Emotional Support Bundle

Advocate Children's Hospital, a 421-bed pediatric hospital with care sites in Oak Lawn and Park Ridge, Illinois, has an emotional support bundle to bring a variety of emotional support options directly to frontline staff. A selection of resources from Advocate Children's Hospital's Embedded Emotional Support Bundle is shown here. It is made up of chaplain-led recovery time, bounce-back kits, moments of silence, and code lavender carts.

The next section details two unique resources from Advocate's Embedded Emotional Support Bundle: chaplain-led recovery time and bounce back kits.

Advocate Children's Hospital Emotional Support Building Blocks

Chaplain-led recovery time

On-unit guided conversations between nurses and chaplains, focused on managing routine daily stressors

Bounce back kits

Premade kits staff can give to each other during times of high stress; kits include reflections on themes, including acceptance, letting go, anger, gratitude, and rest

Moments of silence

Moment of reflection at the beginning of meetings and huddles, or at dedicated times throughout the day

Code Lavender carts

Carts equipped with materials to help staff ground and center themselves during moments of heightened stress



Leverage Chaplains to Alleviate Routine Stress

At Advocate Children’s Hospital, chaplains provide support to frontline staff, as well as patients and families. They provide this support in two ways: individually or on the unit.

For individuals, chaplains offer a series of one-hour group sessions focused managing stress. Staff are often referred by their manager. The goal is to help individuals with higher stress levels, such as a new nurse learning to navigate the practice environment or someone with significant stress in their personal life. At Advocate, the group meets at end of shift once a week for six weeks. New group sessions run four times per year.

For units, managers can request a one-time session for their staff during a time of high stress. One example would be a week with higher than normal patient acuity or a patient mortality. These sessions vary in format, ranging from 15-minute reflections to longer debriefings. Sample topics covered during chaplain-led recovery time are shown below.

Two Options for Providing Chaplain-Led Recovery Time



For individuals

Manager recommends specific individuals attend a series of one-hour group sessions hosted off unit



For units

Manager requests special one-time session for all staff on the unit during high stress periods

Sample Topics Covered During Chaplain-Led Recovery Time

- Chronic stress from caring for high-acuity patients
- Empathic distress from supporting patients, families
- Grief and strategies for coping with loss
- Developing a rhythm of self-care

Specialized Chaplain Roles at Advocate Children’s

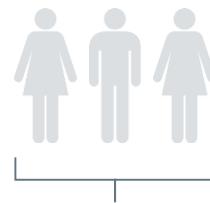
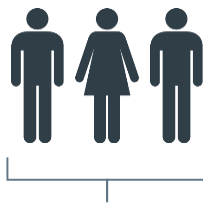
Chaplains at Advocate Children’s Hospital divide their responsibilities to provide support to staff, patients, and families without adding more FTEs. The organizational structure and responsibilities are detailed here.

If your organization doesn’t use chaplains or doesn’t have enough chaplains to provide this type of support to staff, consider using other qualified staff, such as social workers, counselors, or other spiritual leaders.

Chaplain Organizational Structure and Responsibilities at Advocate Children’s

Unit-based assignments

Six chaplains, each assigned to multiple units for 421-bed, two-site hospital; support patients, families, and staff on assigned units as needed



Staff support programs

Three chaplains develop and run organization-wide programs to support staff emotional well-being

Incident response

All chaplains respond to incident-specific needs organization-wide

Give Nurses a Moment of Reflection

The bounce-back kit, pictured here, is another component of Advocate's Embedded Emotional Support Bundle. Each bounce-back kit is a small care package with a variety of low-cost items that relate to a theme. For example, the relaxation kit includes a reflection exercise, a coloring book, earplugs, and candles.

Kits are stored in a central location, where anyone—staff or managers—can access the kits at any time to give to a colleague.

Advocate Children's' Bounce-Back Kit



Sample Themes:

- Acceptance
- Letting go
- Anger
- Gratitude
- Rest

Sample Content:

- Reflection exercises
- Coloring materials
- Earplugs
- Candles

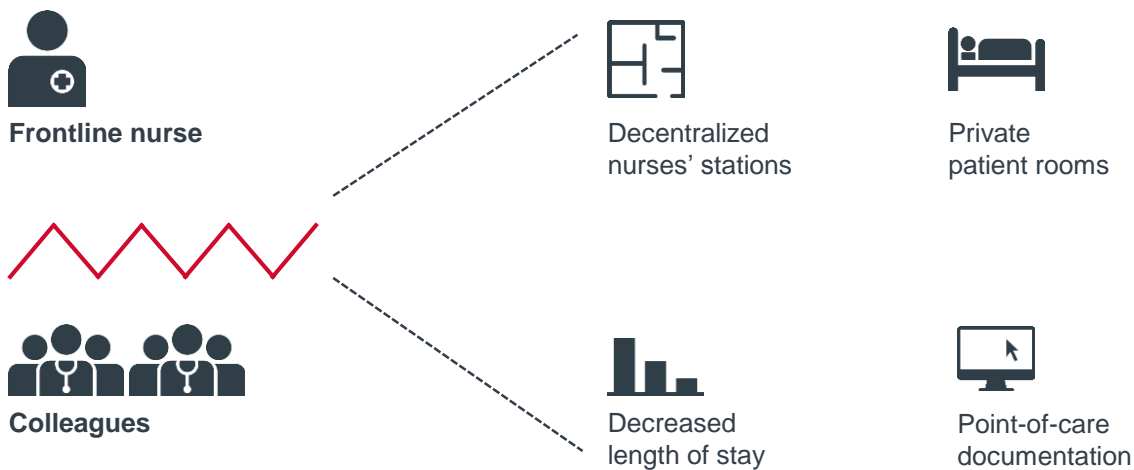
▶ Reconnect Nurses Through Storytelling

- Practice 9: 90-Second Storytelling
- Practice 10: Routine Clinical Reflections
- Special Report: Addressing Incivility
- Practice 11: Float Nurse Unit Civility Survey
- Practice 12: Staff-Driven Code of Conduct

Nurses Feel “Isolated in a Crowd”

The fourth foundational crack that undermines nurse resilience is that new technology, responsibilities, and care protocols cause nurses to feel “isolated in a crowd.” Put another way, nurses often feel they are working alone, even though they are surrounded by people during their shifts. Changes in care delivery processes have led to more isolated work streams. For example, nurses are increasingly expected to document care at the bedside, rather than at a central nurses’ station. And as facility design strategies evolve to improve patient satisfaction, prevent spread of infection, and reduce costs, more hospitals are building single-occupancy patient rooms. As a result, nurses report feeling more isolated than part of a team.

Key Factors Contributing to Nurse Isolation



Leaders must continue to strive for care processes that improve efficiency, care quality, and patient experience, even if they lead to more isolated work streams. But there is a solvable challenge, which is described on the next page.

Nurses Have Few Opportunities to Connect with Peers

The solvable challenge that leaders can address is that nurses have limited opportunities to connect meaningfully with their nursing peers.

The perspectives shown here highlight a few examples of testimonials shared by frontline nurses during focus groups conducted by the Nursing Executive Center.

Representative Frontline Perspectives

“

“I have spent several shifts where it feels like I haven’t talked to anyone except my patients and the care team when we’re rounding. But during rounds, we’re only talking about the patient’s care plan and what’s on deck for the day.”

Frontline Nurse

“

“I remember, just the other day, walking down the hall and not seeing anyone. I had a funny story to share, but I couldn’t find anyone to tell it to!”

Frontline Nurse

“

“If I see a nurse struggling, I’ll jump in and help them. If I do, we focus on the job—but I don’t always have a chance to ask her how she is doing after we take care of the situation.”

Charge Nurse

“

“We have to make sure we care about our coworkers as humans first. But we’re so busy with admissions and discharges, and everything else in between, that we don’t get to connect as people, as friends.”

Frontline Nurse

Reconnect Nurses Through Storytelling


The executive strategy is to reconnect nurses through storytelling.

Shown here are top-level insights from recent studies that describe the positive impact of storytelling on interpersonal connections. For example, a 2014 article from *Forbes* reports that when individuals share their own real-life stories or the stories of others, they are more likely to be perceived as authentic people, and that storytelling is one of the most effective ways to build human connections.

The first two practices in this section can help leaders reconnect nurses to each other through storytelling.

Sample Articles Acknowledging the Power of Storytelling




 **Tap the Power of Storytelling**

Real-life stories authentically *connect* the listeners to the storyteller. Struggles and successes are shared, and the audience can empathize with the storyteller.

Forbes, 2014




 **The Psychological Power of Storytelling**

Stories encourage collaboration and connection, through which we share meaning and purpose with others. They help us find commonalities with others.

Psychology Today, 2011



 **The Irresistible Power of Storytelling as a Strategic Business Tool**

Successful stories focus listeners' minds on a single important idea. It takes only a few seconds to make an emotional connection between the storyteller and listeners.

Harvard Business Review, 2014

Source: Duncan RD, "Tap the Power of Storytelling," *Forbes*, 2014 <https://www.forbes.com/sites/rodderdeanduncan/2014/01/04/tap-the-power-of-storytelling/#14456335614a>; Rutledge PB The Psychological Power of Storytelling. *Psychology Today*, 2011 <https://www.psychologytoday.com/us/blog/positively-media/201101/the-psychological-power-storytelling>; Monarth H The Irresistible Power of Storytelling as a Strategic Tool, *Harvard Business Review*, 2014 <https://hbr.org/2014/03/the-irresistible-power-of-storytelling-as-a-strategic-business-tool>; Nursing Executive Center interviews and analysis.

Practice 9: 90-Second Storytelling

Practice in Brief

Begin all meetings and huddles with a 90-second story, in which a team member volunteers to share a personal experience. The goal is to hardwire opportunities for nurses to connect with each other through personal stories.

Rationale

The unintended consequence of electronic documentation and efficient care delivery is that nurses spend more time working in isolation, with limited opportunities to meaningfully connect with their nursing peers. By dedicating the first few minutes of each meeting or huddle to a brief nursing-related story, you can build opportunities for nurses to share their personal experiences on a routine basis and build connection with colleagues.

Implementation Components

Component 1: Begin every meeting or huddle with a 90-second story

Dedicate the first 90 seconds of every meeting or huddle to a brief, personal story. The volunteer storyteller describes a work experience that relates to the organization's mission or core values.

Component 2: Provide clear guidance to keep stories brief

Provide clear guidance to ensure stories include personal details but remain brief and do not overtake the meeting's agenda. Identify a volunteer in advance who will follow a standard structure for the stories. Offer coaching as needed to keep the stories short.

Practice Assessment

We recommend this practice for all organizations because it is easy to implement and sustain. It is a straightforward and simple way to reconnect nurses to each other and their common organizational core values.

Nursing Executive Center Grades:

Practice Impact: B+

Ease of Implementation: A+

Tell a High-Impact Story in Under Two Minutes

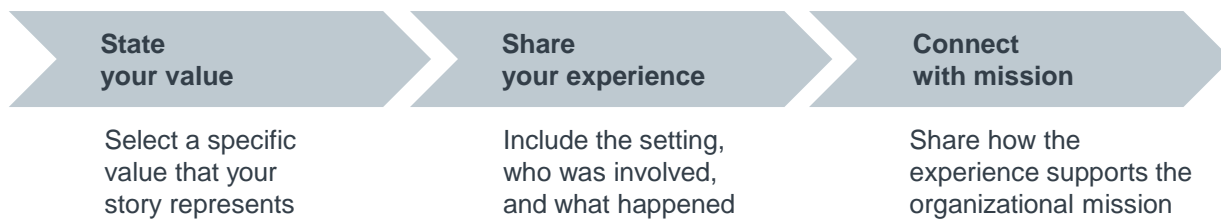
Component 1: Begin every meeting or huddle with a 90-second story

The first component of this practice is to begin every meeting or huddle with a brief, personal story.

The American Nurses Association (ANA), the professional organization for registered nurses in the United States, introduced the 90-second story as a standing agenda item to begin every executive meeting. The purpose was to encourage attendees to acknowledge and reconnect with their purpose in health care.

ANA leaders recommend the process shown below. First, state the core value that the story illustrates. Second, share the experience succinctly but include important details. Third, explain how the experience links to the organizational mission.

ANA's Process for Effective 90-Second Storytelling



Sample core values referenced during 90-second storytelling at the ANA are shown here. You may decide to use your organizational values instead.

Sample Core Values



Clinical excellence



Integrity



Empathy and caring



Joy of practice

Keep Stories Brief to Ensure Sustainability

Component 2: Provide clear guidance to keep stories brief

The second component is to provide clear guidance to ensure storytelling takes no more than two minutes.

ANA leaders shared tips on how to keep stories brief. First, follow a structured format, like the process described on the previous page. Second, select a volunteer to share a story prior to the meeting. Third, offer coaching to ensure the storyteller highlights the important points.

Tips for Keeping Stories Brief



Follow a structured format to ensure stories are concise



Select a storyteller ahead of time to allow individual to formulate their story



Coach storytellers to stay within 90 seconds by reminding them to share high-impact elements

Examples of high-impact story topics are listed here.

Sample 90-Second Story Topics

Achieving a practice-specific goal

Lending a helping hand in a time of need

Persevering through a critical incident

A patient's positive recovery

Practice 10: Routine Clinical Reflections

Practice in Brief

Establish weekly sessions for nurses to share stories and reflect on their experiences in a group setting. The goal is to build regular opportunities for nurses to make meaningful, professional connections with each other.

Rationale

The unintended consequence of electronic documentation and efficient care delivery is that nurses spend more time working in isolation, with limited opportunities to meaningfully connect with their nursing peers. By scheduling weekly sessions for nurses to reflect on their experiences delivering care, you can build regular opportunities for them to share their personal stories and discuss their experiences together.

Implementation Components

Component 1: Establish weekly nurse reflections on the unit

Establish a weekly opportunity for nurses to share personally meaningful work experiences with colleagues and reflect as a group.

Component 2: Recruit frontline volunteers to organize and lead each session

Select two to three staff nurse volunteers to coordinate Routine Clinical Reflections. Before each meeting, the volunteers identify nurses willing to share their experiences, coach them to create succinct stories, and develop discussion prompts as needed. They also ensure Routine Clinical Reflections focus on personal experience rather than technical skills or education.

Component 3: Develop a patient coverage plan that enables wide attendance

Schedule two 30-minute sessions consecutively so all nurses on a given shift can attend the reflections. Before each meeting, the manager divides the staff into two groups, relatively equal in experience and skill mix. While the first group attends the first session, the other half covers patient care. After the first session, the two groups switch. The unit manager serves as the emergency contact for any patient care issues that arise during both sessions.

Component 4: Share reflections through additional communication channels

To scale the impact of Routine Clinical Reflections, share summaries of the weekly stories via newsletter or another communication channel. Remove sensitive information (e.g. patient names, demographics, etc.) to maintain confidentiality.

Practice Assessment

This practice is an effective way to help nurses make more meaningful, professional connections with each other. It requires careful planning to cover patient care appropriately. Leaders must consider collective bargaining agreements and staff mix before implementing this practice.

Nursing Executive Center Grades:

Practice Impact: A+

Ease of Implementation: C+

Give Nurses a Platform to Share Stories

Component 1: Establish weekly nurse reflections on the unit

The first component of this practice is to establish a routine, staff-led, group reflection in which nurses can share stories and make meaningful connections with their frontline peers.

Leaders at Sykehuset Østfold, a 633-bed public hospital in the southeastern region of Norway, established Routine Clinical Reflections that provide a forum for staff to share stories and reflect on their clinical experiences as a group. During each weekly 30-minute session, a volunteer shares a personal story about a clinical or professional experience. Nurses participating in the reflection ask questions, offer their perspectives, and discuss how the story relates to their own experience.

Core Elements for Establishing Formalized Nurse Storytelling



Embed a regular process for sharing stories; make it routine



Tell stories from the nurse perspective



Give nurse an audience of their peers for a common perspective

Tap Frontline Volunteers to Organize Reflections

Component 2: Recruit frontline volunteers to organize and lead each session

The second component of this practice is to recruit frontline nurse volunteers to coordinate and direct the weekly reflections. Reflection coordinators have two main responsibilities each week. First, they find and coach a nurse who is willing to share a succinct story during each session. Second, they facilitate the reflections, keeping them focused on the clinical experiences rather than technical skill building or education.

Lead Nurses' Weekly Responsibilities for Unit Reflections at Sykehuset Østfold



Oversee volunteer selection and story preparation

Select volunteers to share a specific clinical experience; provide guidance on effective storytelling to speakers



Facilitate reflections to maintain focus on experience

Facilitate discussion to focus on experience; redirect if group shifts to discuss clinical competencies or education

At Sykehuset Østfold, three volunteer nurses on each unit share responsibilities for coordinating Routine Clinical Reflections. The combined time commitment for all three frontline reflection coordinators is about one hour per week.



3–4 RNs

Number of volunteer nurses who organize unit reflections

1 hour

Estimated total staff time dedicated to weekly prep for unit reflections

Enable Wide Participation

Component 3: Develop a patient coverage plan that enables wide attendance

The third component of this practice is to develop a plan that covers patient care safely during reflections and enables all staff to participate in the reflections at least once per month.

At Sykehuset Østfold, weekly reflections are scheduled as two consecutive 30-minute sessions. On the morning of the reflections, the unit manager divides the staff into two groups. One group attends the first reflection while the second group covers patient care on the unit. Then the two groups switch. To ensure appropriate care coverage, the unit manager makes the groups as balanced as possible, considering staff skill mix and experience. The manager also provides additional support to the group providing care, by rounding on patients and responding to urgent patient needs when staff need assistance.

Sykehuset Østfold's Unit Coverage Plan



Nurse Unit Manager's Role



Staff rounding

Rounds on staff prior to unit reflection to assess patient load for reassignment during reflections



Patient reassignment

Creates roster for patient coverage for each 30-minute meeting, based on nurses' skills and patient acuity



Emergency contact

Covers urgent patient care situations, protecting time for nurses in the session

Additionally, leaders at Sykehuset Østfold recommend keeping two things in mind when scheduling Routine Clinical Reflections. First, schedule reflections in a way that allows all staff to participate at least once per month. Since staff at Sykehuset Østfold rotate shifts, leaders scheduled Routine Clinical Reflections at a consistent time each week. Second, use census data and knowledge of care activities on each unit to schedule reflections at times when demands on staff tend to be lighter.

Scale the Impact of Routine Reflections

Component 4: Share reflections through additional communication channels

The final component of this practice is to scale the impact of reflections by sharing them through additional channels to ensure a wide audience.

Staff coordinators at Sykehuset Østfold summarize the stories shared in Routine Clinical Reflections, removing patient and staff identifiers, as well as any other protected health information. Leaders share the blinded stories in a weekly unit newsletter. This ensures all staff can benefit from Routine Clinical Reflections, even if they cannot participate in a live session that week.

Representative Weekly Unit Newsletter

Weekly News

Reminders

All RNs need to submit CEs by May 15

Upcoming Events

Sarah – birthday May 1
Nurses' Day – May 12

The Power of Sharing Our Stories

Each week, we share one story told by a nurse during our weekly reflections. This week's story is about the challenge of helping a patient struggling with her personal dilemma about taking pain medications.

I had been working with a patient for about two weeks. One evening, just after my shift began, I walked into her room to find her in tears. I sat down on the edge of her bed and she began to describe what these last two weeks had been like for her. She explained that her pain felt unbearable at times, and she'd had some hard nights. And even though the opiates we were giving her helped the pain, it felt wrong to her to be dependent on the drugs and she didn't like taking them so often. Plus, they made her feel off, tired, and not like herself. She told me she wanted to stop taking the pain medicine, but the idea of handling the intense pain again was daunting. She didn't know what to do and I wasn't sure how I could help.

Short summary of the reflection shared weekly in the unit newsletter

Summary removes patient information to protect confidentiality

Regular Reflections Strengthen Sense of Team

At Sykehuset Østfold, both frontline nurses and leaders feel Routine Clinical Reflections have had a positive impact. Here is some of the feedback received from participating staff at Sykehuset Østfold.

Sample Feedback from Frontline Staff and Leaders at Sykehuset Østfold

“

“In such a specialized department, we are all experienced and very knowledgeable. When we gather to reflect, we meet each other on the same terms, under one story. I think that reflecting helps us strengthen the feelings of being a team.”

Frontline Nurse

“

“I believe that being able to reflect upon your practice as a nurse is most important. As the reflections often have a strong emphasis on both a patient case and how our staff handled the situation, these reflections offer an opportunity to learn and grow on so many levels.”

*Anne Karine Østbye Roos,
Deputy Departmental Advisor, Intensive Care*

“

“This is very positive for me as a manager. I now have a stronger sense of how people are dealing with sensitive cases and can better understand how difficult things can be.”

*Cecilie Kruse-Nilsen,
Sectional Leader Intensive/ Post-Operational Unit*

Addressing Incivility

Practices 9 and 10 tap into the power of storytelling to help nurses make meaningful, professional connections with each other. But if your organization has areas where staff treat each other with incivility or inappropriate behavior, we recommend focusing on preventing those behaviors before you implement those practices. Unless you address incivility first, staff may not be able to experience the full benefit of storytelling.

Incivility is, unfortunately, very common in health care. According to an ANA study of workplace incivility, 50% of nurses report being bullied by a peer and 42% report being bullied by a superior.



Bullying and incivility in any workplace is unacceptable and should never be tolerated. Unfortunately, these behaviors are often underreported and can be difficult to identify. There are several reasons why this is the case; five are described here.

Barriers to Detecting Bullying and Incivility Issues



Bullies keep negative behaviors discreet



New nurses are afraid to report negative behaviors



New nurses are not aware their treatment or work environment should be different



Directors and managers don't have time or capacity to closely monitor so many direct reports



Executives can't spend extensive time on unit due to competing priorities

To help you identify and address any areas in your organization where incivility or bullying is occurring, we have included two additional practices on the following pages.

Source: Sachs A, Jones J, "ANA Sets 'Zero Tolerance' Policy for Workplace Violence, Bullying," *American Nurses Association*, August 31, 2015, <http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/ANA-Sets-Zero-Tolerance-Policy-for-Workplace-Violence-Bullying.html>; Nursing Executive Center interviews and analysis.

Practice 11: Float Nurse Unit Civility Survey

Practice in Brief

Use a brief survey to collect feedback from float nurses about unit work environments. The goal is to quickly detect units with unfriendly or unwelcoming cultures—and to address problems before they isolate nurses and result in preventable turnover.

Rationale

Incivility and bullying are unacceptable behaviors in the workplace and exacerbate feelings of isolation among staff. But these behaviors are often underreported and difficult to identify. Float nurses can provide an outsider's perspective on work environments and social dynamics in different units. Once leaders can detect problem areas, they can intervene in a timely manner and help all staff feel less isolated and more connected with each other.

Implementation Components

Component 1: Collect feedback from float nurses about their unit experiences

Float nurses and unit-based staff with regular float requirements complete a two-minute electronic survey following their shifts.

Component 2: Monitor performance and intervene where needed

Nursing leaders review trended survey data each month to identify units with consistently low scores or units where civility is deteriorating. Leaders collaborate to identify root causes and appropriate interventions, such as sponsoring a team-building activity, coaching an ineffective leader, or changing unit staffing.

Practice Assessment

We recommend this practice for organizations struggling with incivility and high rates of turnover. The work required to set up and maintain the survey is minimal, and the information collected can help nursing leaders intervene on units with work environment problems before incivility grows and turnover spikes.

Nursing Executive Center Grades:

Practice Impact: A

Ease of Implementation: B

Floating Nurses Provide Unit-Level Perspective

Component 1: Collect feedback from float nurses about their unit experiences

The first component of this practice is to ask float nurses for their perspective on the work environments of various units. Getting this feedback has two benefits. First, float nurses are typically more comfortable offering candid feedback. They do not have to regularly work with the staff or managers on the unit. Second, their experience on a variety of units means that they have multiple points of reference for positive versus negative work environments.

At Saint Luke's Hospital, a 629-bed teaching hospital in Kansas City, Missouri, nurses fill out a survey within seven days of any float shift. The survey consists of seven multiple-choice questions and takes less than two minutes to complete. Dr. Cole Edmonson and Joyce Lee at Texas Health Presbyterian Hospital Dallas initially created the survey, and it is included in the "Stop Bullying Toolkit," available free of charge online from stopbullyingtoolkit.org.

"Heavenly Seven"¹ Float Survey

Post-Float Survey

Based on your last shift, rate your agreement with the following statements:

1. I felt welcome on the unit
2. Someone offered help when I needed it
3. If floated again, I would enjoy returning to this unit
4. I had the resources I needed to complete my assignment
5. I witnessed someone expressing appreciation to another for good work
6. Staff showed concern for my well-being
7. I received appreciation for my work



Benefiting from an Outside Perspective

"It can be the canary in the mine—people working in the environment are not aware of the negative culture. Sometimes it takes someone from the outside to see there is a problem."

*Debbie Wilson
VP / Chief Nursing Officer
Saint Luke's Hospital of Kansas City*

1) The Heavenly Seven is copyrighted by Dr. Cole Edmonson, DNP, RN, FACHE, NEA-BC, FAAN and Joyce Lee, MSN, RN at Texas Health Presbyterian Hospital.

Source: Saint Luke's Hospital of Kansas City, Kansas City, MO; Nursing Executive Center interviews and analysis.

Regularly Share Results with Leaders to Spur Action

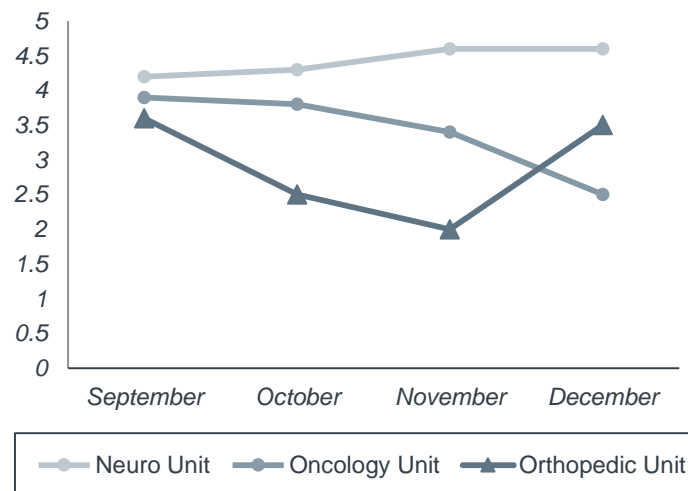
Component 2: Monitor performance and intervene where needed

The second component is to monitor survey scores and other staffing data and intervene on units with poor or deteriorating environments.

At Saint Luke's, nurse leaders use a dashboard to view trended results at the facility and unit level. They can cut the data to view comparisons and identify units with low scores. When a unit's score is consistently low or trending downward, the facility CNO or a director will partner with the manager to create an improvement plan.

Representative Excerpt of Dashboard

Unit Civility Index, 2016



Key Elements of the Unit Civility Index

Centralized data collection



Nursing quality analyst loads all data into spreadsheet for analysis

Filters to view relevant data cuts



Leaders can cut data by hospital, role, or unit

Trended data



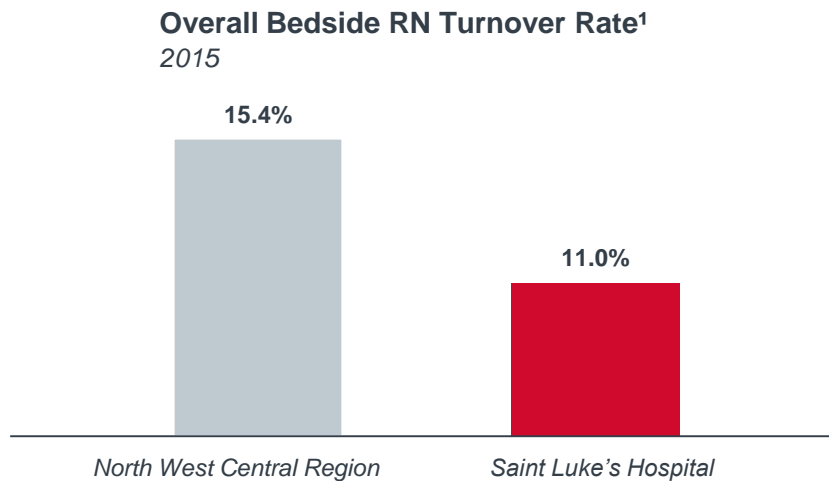
Results from previous six quarters put most recent feedback in context



More details about St. Luke's approach to the Float Survey and Civility Index are available online at advisory.com/nec

Leaders Keep Tabs on Units, Intervene When Needed

The float survey and unit civility index helps nurse leaders detect and improve work environment problems before they lead to isolation among nurses and impact turnover. Turnover at Saint Luke's Hospital is more than four percentage points lower than that of other organizations in their region.



Leaders attribute this success to interventions, shown here, that they have put in place to address bullying, ineffective leadership, and staffing level problems revealed by the civility index.

Sample Interventions on Units with Incivility Problems

-  Conduct focus groups with staff
-  Coach ineffective leaders
-  Sponsor team-building activities
-  Add additional FTEs

1) Excluding PRN, per diem, and casual staff

Source: Saint Luke's Hospital of Kansas City, Kansas City, MO; HR Advancement Center Turnover, Vacancy and Premium Labor Benchmarks, Advisory Board; Nursing Executive Center interviews and analysis.

Practice 12: Staff-Driven Code of Conduct

Practice in Brief

Unit staff develop and commit to a discrete list of specific, actionable behaviors they will follow in their daily interactions. The goal is for nurses to determine the best conduct for their team and hardwire civility into staff and patient interactions.

Rationale

Being the target of unprofessional and disrespectful behaviors can isolate even the most resilient nurse. Organizations need to ensure everyday behaviors promote a sense of team rather than incivility. By creating a unit code of conduct, staff develop a common understanding of and commitment to specific, positive daily behaviors. As a team, they share ownership of those behaviors on the unit.

Implementation Components

Component 1: Facilitate staff reflection about appropriate unit behavior

A trained facilitator leads a structured session in which staff reflect on which behaviors build a collaborative, inclusive, and compassionate environment and which behaviors damage it. They discuss the broader impact that both the positive and negative behaviors can have on their team, patient care, and patient experience.

Component 2: Establish individualized code of conduct for each unit or care site

Frontline staff develop a formal code of conduct for their team, based on the behaviors discussed during the facilitated group reflection. All staff formally and publicly commit to following their care team's code of conduct.

Practice Assessment

Any organization experiencing incivility among staff should implement this practice. It requires minimal investment and effort but generates both stronger staff connection and improved compassionate caregiving on units.

Nursing Executive Center Grades:

Practice Impact: A-

Ease of Implementation: B+

Staff Evaluate Current Behaviors on Unit

Component 1: Facilitate staff reflection about appropriate unit behavior

The first component of this practice is to have staff reflect on what kinds of behaviors are appropriate and inappropriate for the care team.

Leaders at Northumbria Healthcare NHS Foundation Trust, a 1,375-bed acute care hospital in North Tyneside, England, facilitated staff-driven development of unit-specific “codes of conduct.” They used a trained facilitator to lead discussions about behaviors, keeping the conversations focused and productive. The facilitator engages nurses in discussions regarding practice on the unit. This includes reflection on what individual nurses feel is done well on the unit and what needs to be improved.

Following this conversation, the facilitator prompts individual nurses to share their opinions about how behaviors can be improved. These ideas are anonymous but are collected on large charts set up in staff-only areas.

Key Components for Engaging Staff in Setting Standards of Behavior



Ensure facilitator credibility

- Selected facilitator has existing or gains credibility on unit
- Objective, positive individual dedicated to understanding the staff perspective



Engage in open dialogue to reflect on practice

- Structured questions promote staff reflection on “always” and “never” behaviors
- Safe, “no-blame” environment for staff to share thoughts



Lead staff in articulating commitment

- Staff agree upon discrete list of clear behaviors and create a code of conduct
- Conduct code signed by all staff to solidify commitment

Ensure Shared Understanding of Expectations

Component 2: Establish individualized code of conduct for each unit or care site

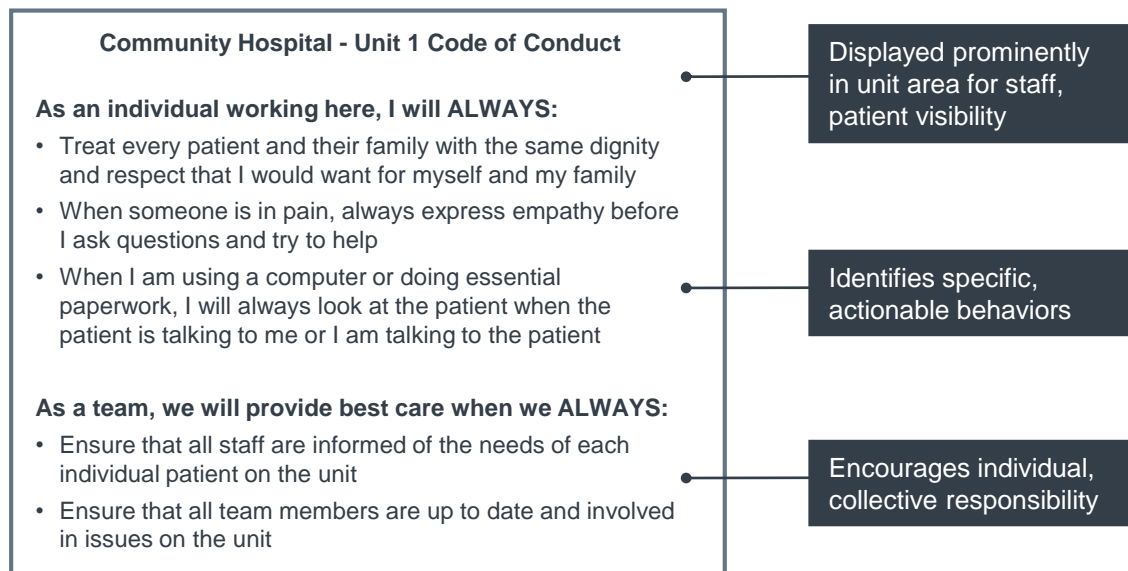
The second component is to develop a specific code of conduct for each unit or care site to which all staff commit.

Once ideas about improving behaviors on the unit have been compiled, the facilitator leads the group in a discussion to decide which behaviors they want to commit to as individuals and as a team. They use specific and actionable terms when developing the list, reducing risk for misinterpretation.

There may be a common organizing structure for codes across the organization. You may choose to use your values as a framework. At Northumbria NHS Trust, staff listed “always” and “never” behaviors, shown here. Regardless of structure, the behaviors must be relevant to the team’s context.

The entire staff agrees to these behaviors as individuals and as a team. At Northumbria, staff formally committed to the codes by signing a poster of their code of conduct. This is posted publicly on the unit as a reminder and reference point. It reinforces staff commitment to the behaviors.

Example Unit Code of Conduct



Improving Teamwork, Patient Satisfaction

Both staff and patients benefit from a Staff-Driven Code of Conduct. Staff feel more connected with each other and with their teams, decreasing feelings of isolation. One nurse's feedback is shown here.



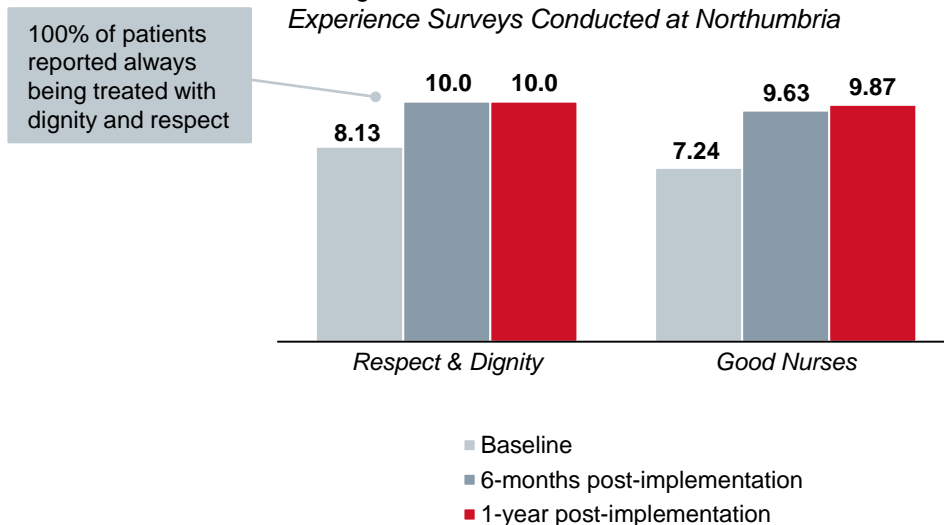
All I wanted was to be proud of the team and the care we provide, and now I really am.

*Staff Nurse
Northumbria Healthcare NHS Foundation Trust*

Patients have also seen a benefit. Results from Northumbria's real-time patient experience surveys are shown here. One unit received a sustained perfect score in the "respect and dignity" domain of these surveys following the development of their unit code of conduct.

Patients Reporting Increase in Satisfaction

Average Score Out of 10 on Real-Time Patient Experience Surveys Conducted at Northumbria



Source: Northumbria Healthcare NHS Foundation Trust, Northumberland, UK; Nursing Executive Center interviews and analysis.

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