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Behavioral challenges:

A novel approach to mental health workers in medical nursing

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Has society's social incivility, from consumers to politics, reached an all-time low? In healthcare, there's an underlying culture of acceptance of poor patient behavior. Hospitals and regulatory agencies have for a long time focused on patient perception and safety, and less on worker safety. Consequently, there's a lack of awareness regarding the frequency of workplace violence and its impact on employees. Hospitals can be dangerous places, with a steady increase in the number of behavioral health patients being admitted to medical floors. Comorbidity is currently expected and is no longer an exception. Patients are increasingly presenting to acute care hospitals in crisis because there are fewer community-based programs or available psychiatric inpatient beds. Patients with behavioral health issues may be diagnosed or undiagnosed with a psychiatric or substance use disorder.

There are safety risks that come with having behavioral patients on a nonpsychiatric medical floor. Additional resources, such as unlicensed assistive personnel (UAP) for 1:1 observation and considerable security resources, get allocated to this population, which increases care costs and length of stay. In addition, patient satisfaction and staff engagement scores are affected as nonbehavioral health patients are disrupted and may be fearful of having a roommate who's loud and potentially visibly violent. Staff members may fear for their own safety if a patient lashes out verbally or physically. Staff members may not feel confident in their skills to care for these patients if they've never received formal or ongoing training for patients with mental health disorders.

Several US hospitals are integrating medical and psychiatric services. Some have their psychiatric physicians and mental health teams round on medical floors and provide consultative services. Other hospitals have created new combined units dedicated to the high medical acuity and behavioral health population-unit staffing patterns can provide a multitier approach to de-escalating behavioral patients, reducing usage of 1:1 observations, improving staff knowledge regarding behavioral patients, and increasing staff engagement scores and operational efficiency. This article describes one unit's experience with this model in an urban academic medical center.

First-year results of imbedding mental health workers into a medical inpatient unit demonstrated a significant impact on 1:1 observation utilization and staff engagement scores.

Current state and statistics

Violence against healthcare workers is at an all-time high, with EDs and behavioral health inpatient settings seeing the highest number of incidents.[2-5] Nearly every healthcare professional has been a victim of violence, and the reported rates of tions.[1] However, these interventions are only the tip of the iceberg. The former only provides intermittent support and the latter has significant financial impact and can be limited based on infrastructure and space needs. Nurses and nurse leaders are looking for a fresh approach to caring for these patients, as well as ensuring staff safety and positive patient experiences.

Mental health workers (MHWs) imbedded in medical violence are likely higher because healthcare worker reporting is voluntary.[2,3,5] Nursing staff members and direct caregivers are at the greatest risk for an assault by a patient because of their frequent contact and close proximity to patients.[3] Many patients admitted to US hospitals have depression, bipolar disorder, schizophrenia, other mental health disorders, and/or substance use disorders.[6] There's been a substantial rise in hospital patients with addiction disorders, from 20% to 50%.[7]

Along with this influx of behavioral health patient admissions has come an increase in violent crimes against healthcare workers.[3,8,9] The Joint Commission notes that multiple injuries have been reported, including bruises, lacerations, fractures, and even loss of consciousness after attacks from patients.[2] As a result of violent behaviors, staff members often have increased rates of time away from work, burnout, job dissatisfaction, unproductiveness, and reports of feeling unsafe.[2,3,8]

Overall, increased numbers of behavioral health and substance abuse/dependence patients are

seeking care at general hospitals. Many are considering this shift a nationwide mental health crisis. The influx of this patient population into EDs and nonbehavioral health inpatient medical units has caused distress due to increases in violent crimes against healthcare workers, particularly nursing staff members.[7]

Background and effects

Often, clinical nurses outside of behavioral health units receive little to no training or education on how to effectively handle behavioral health patients' outbursts. Attempts to keep healthcare workers safe when caring for behavioral health patients exhibiting aggressive or violent behaviors have typically resulted in traditional measures, including the use of restraints, sedation, 1:1 observation, and/or social isolation. Unfortunately, many of these interventions are reactive, short-term solutions that neglect to address or change behavioral patterns.[10]

Patients who are repeatedly chemically or physically restrained may see violence as an effective way of expressing their fear, anger, or frustration.[10] Alternative approaches need to be taught to patients and staff so they can work to de-escalate patients' behaviors and set limits for a more sustainable and safer approach to care.[10] The use of traditional measures can lead to negative effects, including, but not limited to, increased staff turnover, poor engagement scores, staff burnout, increased fear and injuries sustained by caregivers, and lower patient experience scores. In addition, each of these effects can impact an organization's financial outlook.

At a major academic medical center in New York City, behavioral health patients were presenting multiple challenges. On one 32-bed general medical-surgical unit, there was a sharp increase in staff injuries, resulting in the previously mentioned negative overall effects. There was also a significant financial impact, with increases in the use of 1:1 observation and social isolation requiring private rooms and blocked beds for behavioral health patients. Nurses on the unit reported that some behavioral health patients were disruptive and feared by staff and other patients because they were loud and often visibly violent. Staff members weren't confident in their skills to effectively care for the mental health disorders that many of the patients had as comorbidities to their medical diagnoses. The environment was one that required an innovative approach to challenges with behavioral health patients.

Need for innovation

Nursing leadership began this approach by holding focus groups with staff members on the unit. Eliciting staff members' feedback and suggestions was an important first step, particularly because the hospital was embarking on its Magnet® journey at the time. Over the course of multiple debriefings, several themes emerged. Staff members wanted additional education on how to adequately handle patients' behavioral outbursts and recognize the warning signs before patients became physically violent. In addition, staff members desired additional resources to help with the unique needs of this patient population.

One of the next steps was to find a way to provide additional education, training, and emotional support for the staff members providing care to behavioral health patients in the inpatient medical setting. Nursing leadership collaborated with the nursing education department to explore a variety of programs to address staff members' lack of training regarding the behavioral health population. The group settled on training from the Crisis Prevention Institute. Taught by a psychiatric nurse educator, the training focused strongly on threat recognition and proactive de-escalation techniques. Additionally, the program provided a practical skill set for staff members to safely extricate themselves from a violent encounter with a patient. This training became mandatory for all staff members working on the unit, and regular ongoing debriefings were instituted to provide emotional support. Led by psychiatric nurse educators and physicians, these debriefings became a space for staff members to further troubleshoot ideas for how to de-escalate behaviors and set limits.

Another step was to strengthen partnerships with key players outside the nursing department. Nursing leadership coordinated with hospital security to initiate hourly rounding on the medical units where most of the behavioral health patients were admitted. These hourly rounds included security staff members checking on the known behavioral health patients and those

on 1:1 observation, as well as checking in with the charge nurse on duty to ensure that there were no other safety needs or concerns at the time. In addition to providing a better sense of safety, staff members grew stronger relationships with the security team during these hourly rounds.

Nursing leadership also escalated staff members' concerns to the hospital's senior leaders, including the CNO, chief operating officer, and chief medical officer, in the search for new solutions. Utilizing the support of the hospital's senior leadership and experts in the psychiatry field, the decision was made to imbed MHW positions on the unit that cares for the most behavioral health patients. The MHW would have a new hybrid role, assisting in taking care of medically ill patients while using his or her psychiatric expertise to help manage and de-escalate the growing mental health population on this inpatient medical unit.

MHW intervention

The goals and expectations of the MHW program are to decrease 1:1 observation on the unit, contribute to an improved sense of staff safety, and improve the overall patient experience. With this goal in mind, senior hospital and nursing leadership advocated for 5.2 additional full-time equivalents to hire a full complement of 24/7 MHW coverage in the form of one part-time and two full-time positions for both the day and night shifts. With approval for the positions secured, the next step was to define the new role.

The role of the mental health technician in inpatient psychiatry provided a starting point for defining the role. While adapting it to the inpatient medical setting, the role was modified to a new hybrid model, blending psychiatric expertise with the ability to assist patients with activities of daily living (ADLs). In the inpatient setting, MHWs are expected to round on patients throughout the shift, particularly focusing on those with psychiatric diagnoses or comorbidities. They also work closely with patients on 1:1 observation and help de-escalate patients and visitors if they're having an outburst. They're trained to perform vital signs assessment and help with ADLs to assist nursing staff and address the medical needs of this patient population. With the new role defined, focus shifted to the interview process and finding employees who would be the right fit for the unit and the new role.

Nursing leadership was also committed to seeking innovative, creative individuals with leadership skills to build and develop the new program. An ideal candidate had both MHW and UAP experience, with effective communication skills and the right motivational fit for the unit. Candidates went through a series of interviews, including frontline unit staff. During the panel interview, there was transparency with the candidates regarding both the patient population and the expectations required in this new hybrid role. Candidates were also asked to describe how they would respond to specific examples of outbursts by behavioral health patients that had previously occurred on the unit.

Nursing leadership partnered with nursing education to create a new purposeful and meaningful orientation model that drew upon elements from UAP orientation, as well as mental health technician orientation. Orientees spent time training on both an inpatient medical unit and an inpatient psychiatric unit. After orientation, the focus was on integrating the MHWs into the unit and having staff members fully understand their role. This was a struggle at first, and clear communication was needed to reeducate staff members regarding the role and purpose of the MHWs.

The MHWs continued to do a large amount of education with the team regarding not only their purpose on the unit, but also how to best interact with each patient's combination of psychiatric conditions to minimize the risk of escalation. They also attended interdisciplinary rounds and worked collaboratively with the nursing and medical teams to make suggestions for patients' behavioral care plans. Additionally, they created an activity cart for the unit with items such as books, puzzles, and art supplies that could be offered to patients to provide a distraction during their stay in the hospital.

Outcomes

Through the implementation of the MHW program, the unit witnessed several outcomes as a result of decreased 1:1 observation usage, improvement in staff engagement, increased patient experience, and better recruitment strategies. The amount of clinical 1:1 observation hours decreased from 4,054 to 3,391 from fourth

quarter 2014 to fourth quarter 2017. (See *Figure 1.*) This was a significant accomplishment that not only impacted the unit, but also the organization's bottom line, improving operational excellence. The reduction in 1:1 observation usage also led to UAPs being utilized in their full capacity, helping support nursing staff members and patients instead of being assigned to 1:1 observation.

At the beginning of the MHW program implementation, staff members were actively disengaged and dissatisfied with their work environment. Staff engagement increased from 3.6 to 4 from 2015 to 2017. (See *Figure 2.*) The staff engagement grand mean of 4.0 was the organization's average.

To assess the patient experience, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) communication with nurses and care transitions domains were monitored. Neither domain was found to have much of a change between the initial and final data points; however, there was some progress made, causing a positive trend line to be observed in both domains. From fourth quarter 2014 to fourth quarter 2017, the communication with nurses domain went from 72.3 to 72.2 and the care transitions domain remained unchanged at 46.7. (See *Figure 3.*) Although the results were essentially unchanged, there were periods of positive fluctuating trends.

Throughout implementation of the MHW program, it became apparent that we needed to recruit and retain the right staff members. This was pivotal in the success of the program.

Figure 1: Constant observation (1:1)

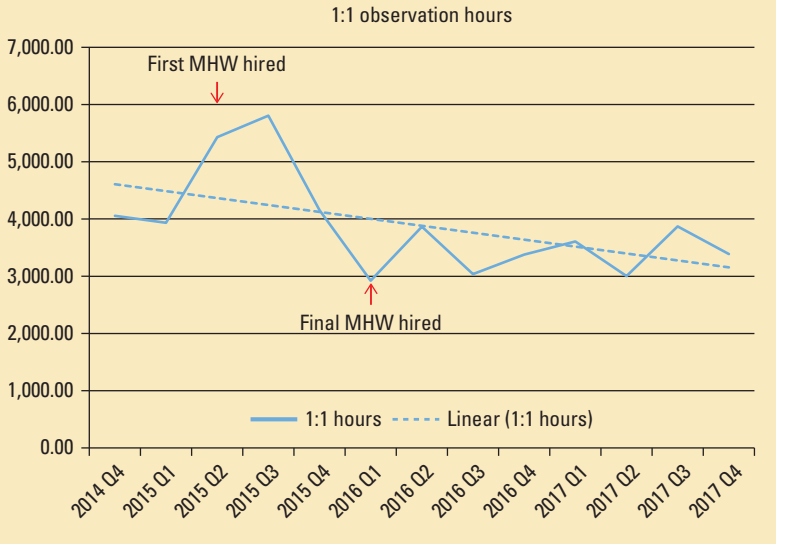


Figure 2: Staff engagement scores

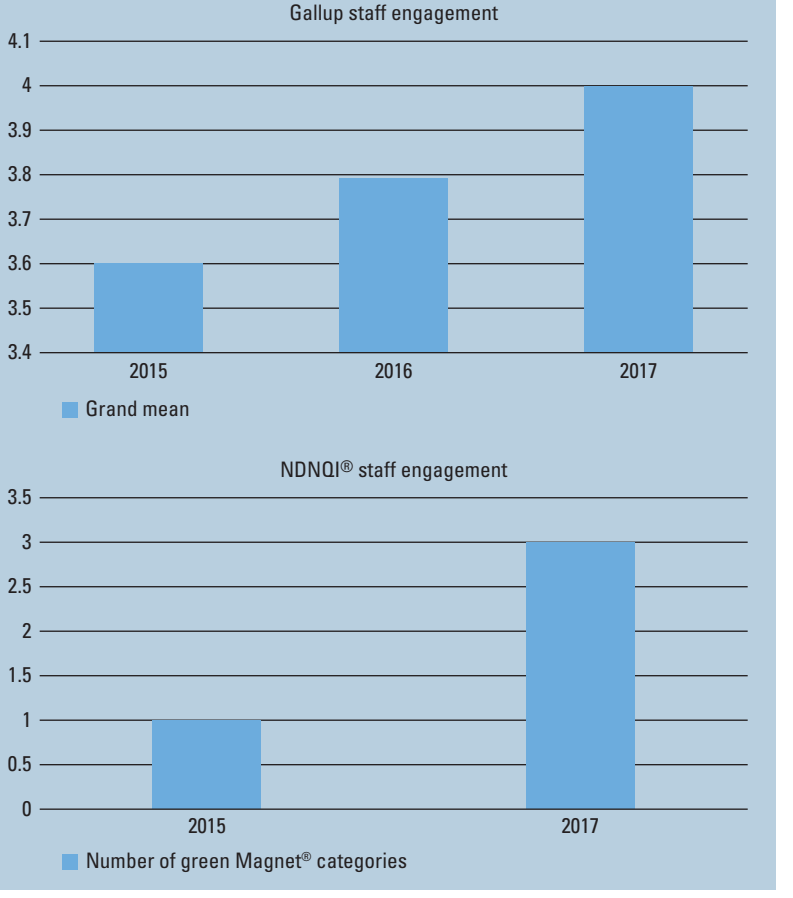
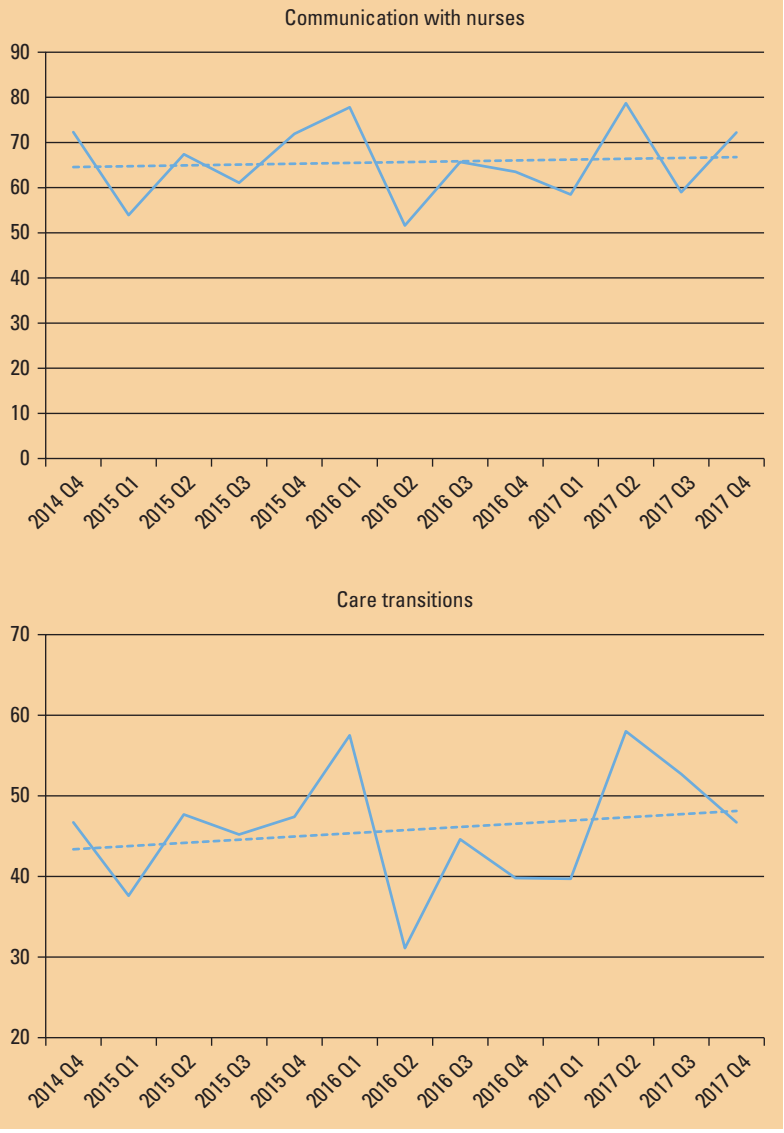


Figure 3: HCAHPS scores



During the interview process, candidates were given examples of the behavioral challenges faced on the unit and asked how they would respond if put in a given situation. Some candidates were candid and didn't want to "deal" with behavioral health patients, whereas others were up for the challenge. This resulted in better recruitment for the right fit.

Barriers and limitations

Over the course of the MHW program, it became evident that several challenges remained. For example, one of the MHWs hired didn't pass the probation period. MHWs are accustomed to working on locked behavioral health units, so they must adjust work routines. One of the limitations of this study was the variability in patient experience scores. Numerous factors affect patient experience, so it was difficult to quantify the impact of the MHW program. It was also difficult to accurately quantify staff harm because some incidents go unreported, although there was an increase in reporting, showing that staff members had bought into the idea of worker safety being important—a positive cultural indication. Another limitation was that this program was implemented on a 32-bed medical unit, so it was difficult to determine if it would be equally successful on different units.

Conclusion

First-year results of imbedding MHWs into a medical inpatient unit demonstrated a significant impact on 1:1 observation utilization and staff engagement scores. Targeted education, frequent security rounding, case study debriefings, and specialized recruitment and staffing contributed to nurses feeling supported, protected, and better suited to care for the challenging behavioral health patient population. These actions are the first steps in creating a healthy work environment and preventing staff harm in the healthcare setting.

Research is needed to evaluate and expand services to incorporate next steps, such as rapid psychiatric response teams, electronic flagging of known threatening patients, additional environmental analysis and hazard controls (such as metal detectors and personal alarms), codes of conduct and behavioral contracts to define and manage behaviors, daily organizational

safety huddles, and zero workforce violence tolerance programs. No one should ever feel that violence is an acceptable part of his or her job. NM

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