Behavioural Safety Review (BSR)

Supporting meaningful conversations after patient-to-worker harassment or violence

The Behavioural Safety Review (BSR) is a voluntary clinical tool for completing *safety debriefs* after patient-to-worker harassment and violence – including patients/clients, families or visitors**.**

All forms of debriefing allow teams to have meaningful and supportive conversations to enhance communication, facilitate teamwork, process thoughts and feelings, and support better outcomes for our patients, staff and physicians. Safety debriefs are one option on a spectrum of debriefings.

Safety debriefs focus on supporting staff and patients after incidents and identifying quality improvement opportunities. They help us achieve a culture of safety, continuous learning and improvement, and safe reliable processes and healthcare services – which are key enablers to patient and worker safety and experience.

BSRs are a way of gathering and sharing of information in a psychologically safe manner after incidents of patient-to-worker harassment and violence/aggression. The tool uses principles of Just Culture to gather facts, share perspectives, build trust, provide support and increase resiliency. It is not about finding fault, blaming or investigatory in nature.

A manager/supervisor, physician, clinical lead, charge nurse, clinical educator or others who support harassment and violence prevention and response can lead this review.

Outcomes from completed BSRs should be shared with managers/supervisors, physicians and/or patient safety or quality improvement consultants, and stored locally to support quality improvement strategies.

Conducting a Behavioural Safety Review

What are you noticing after the incident?

- Reflect on what you are sensing prior to the discussion
  - How are impacted workers doing? What have you observed or heard?
  - Is additional support required?
- Gather factual data that may be useful during the upcoming BSR

Getting it organized

- Pick a time to meet (preferably within three (3) days of the event), for 30-60 minutes
- Be clear about the purpose of the discussion when inviting participants
- Include all workers involved (e.g. unit staff, support services staff and Protective Services)
- Include the patient and family/caregiver, when able
- Include the patient's physician or the most responsible physician at the time of the event

Attendees:

Name	Role

Planning your approach

Key elements for effectively supporting staff and physicians during the discussion include:

- Active listening, seeking to understand
- Acknowledging individual reactions with compassion and without judgement
- Encouraging discussion and sharing
- Acknowledging signs of conflict, supporting as needed
- Reframing expectations when appropriate
- Working through shared learnings
- Supporting mental health
- Celebrating what went well during the event

Support looks different to each individual. The most important thing is for those involved in the event have an opportunity to share and be supported.

Steps and suggested script

1. Open the discussion

- *"Thank you for attending today. We would like to spend this time having a respectful and supportive discussion about the event that occurred on _____."*
- *"This is an opportunity to celebrate what went well and promote shared learnings and collaboration with the patient/family/caregiver."*
- *"I'll share recommendations from our discussion with unit leadership and other relevant groups."*
- *"Further conversations may occur with our team/support programs, management, Physician Dyad and Senior Management. Senior Management may recommend we ask for support from our local WHS Advisor and/or Violence Prevention Coordinator if we haven't done so. Senior Management will determine if the outcome actions will be shared with local JWHSCs for review."*

2. Review and document what happened

- *"Can someone get us started by summarizing what happened?"*
  - Prompt for factual details, including:
    - Timelines
    - Who was involved from other departments
    - What was known about the patient/family/caregiver before the interaction (e.g. presence of a behavioural safety care plan, including an Alert)
    - Possible contributing factors:
      - in the care environment
      - for the patient (e.g. clinical presentations, wait times, other possible triggers)
      - for the responding staff
  - Invite other perspectives
    - *"Did anyone notice anything else they would like to share?"*
    - *"Is there anything that hasn't been mentioned?"*

Notes

3. Shared learnings

- "*What went well?*"
- *"What could we have done differently?"*
  - Were assessments completed and documented?
  - Were barriers/gaps identified?
  - Is further information or support needed?

What went well:	Learnings:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Reporting

- Has a report been completed in MySafetyNet (MSN)? ❑ Yes ❑ No
  If you selected no, why not?
- Has a report been completed in Reporting and Learning System (RLS)? ❑ Yes ❑ No
  If you selected no, why not?

5. Debriefing with the patient/family/caregiver (where possible)

- *"Did we speak with the patient, family/caregiver before and/or after the event?"*
  - Are there any comments/learnings to share about these interactions?
  - What do we understand about what triggered the event?
    - Was this validated with the patient, family/caregiver?
  - Was a behavioural safety care plan in place (see below)?
  - Is there any further action to be taken to ensure collaboration with the patient, family/caregiver continues?

6. Behavioural safety planning, communication and collaboration

- *"Is there anything more we should do to improve patient experience and worker safety?"*
  - Create a behavioural safety plan with the patient/family/caregiver. Apply an Alert, if needed.
  - Identify required unit system changes
  - Identify required patient care/routine changes
  - Identify opportunities to improve communication with patients/family/caregiver and team
  - Determine is necessary staffing, equipment/supplies are available

Notes

_____

_____

_____

_____

_____

_____

7. Next steps

Summarize takeaways and next steps. Determine individual/team responsibilities for implementation of which changes (while following the local quality improvement/process change structure).

- "*Does anyone have anything to add?*"
- *"Thank you for participating."*

Encourage members to reach out if anyone missed the meeting and/or who have more to share. Check in with members of the team after the discussion to ensure psychological well-being is supported and share the self-care tools below.

Remember to share outcomes of the BSR with managers/supervisors, physicians and/or patient safety or quality improvement consultants to support quality improvement strategies.

Notes

_____

_____

_____

_____

_____

8. Supporting resources

Be proactive. A manager or supervisor can arrange immediate support by calling the Employee Family Assistance Program (EFAP) at **1-877-273-3134** and asking for Crisis Management Support.

Support for **Physicians/Residents** can be found at Alberta Medical Association and by calling 1-877-SOS-4MDS (1-877-767-4637) for 24/7 support.

Additional resources to support staff/physicians include:

- Mental Health & Well-being:
  - Burnout (Infographic)
  - Self-Compassion Information Sheet
  - AHS Resilience, Wellness and Mental Health Resource Guide
  - EFAP Postcard
- Psychological Safety:
  - How do I support someone who is struggling?
  - Psychological Safety Tool Kit
- Worker Safety:
  - Worker-to-Worker Behaviour Continuum
  - Workplace Harassment & Violence Prevention
    - Find information about prevention planning, the Behavioural Safety (Alerts) Program, prevention training, and Safe Care Together posters.
  - Contact your local WHS Advisor for further support with safety investigations and corrective actions, including harassment and violence prevention planning.

Date: _____ **Facilitated by:** _____