Behavioral Emergency Response Team

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Why a Team

- In 2010, the Bureau of Labor Statistics (BLS) data reported healthcare and social assistance workers were the victims of approximately 11,370 assaults by persons; a greater than 13% increase over the number of such assaults reported in 2009.
- Almost 19% (i.e., 2,130) of these assaults occurred in nursing and residential care facilities alone.

https://www.osha.gov/SLTC/healthcarefacilities/violence.html

Why Cont.

- In 2012 the Division of Mental Health, Developmental Disabilities and Substance Abuse Services reported 150,000 people with psychiatric needs ended up in emergency departments around the state in 2012.
- The length of stay for the patients average about 3.5 days, or more than 84 hours.

http://www.northcarolinahealthnews.org/2013/11/08/mental-health-crisis-initiative-announced/

DEFINE the Problem

Safety of patients, staff and providers is compromised due to:

- Behavioral challenges presented by patients in non-Behavioral Health care areas (agitation, withdrawal, dementia, other psychiatric complications)
- Limited resources to prevent and manage disruptive behavior
- Lack of coordinated process to respond to events
- Staff feeling unsafe, unsupported, and poorly prepared
- Administration concerned with assaults on staff and major safety events

Goal: Enhance safety of patients, staff & providers by creating:

- A rapid response service to assist caregivers in deescalating behaviors that threaten the safety of the environment

Design Team

- Staff Psychiatrist
- Patient Safety Officer
- Nursing Administration
- Security
- Behavioral Health Intake Director
- Risk Manager
- Accreditation Specialist
- Quality Improvement Advisor
- Medical Director Behavioral Health

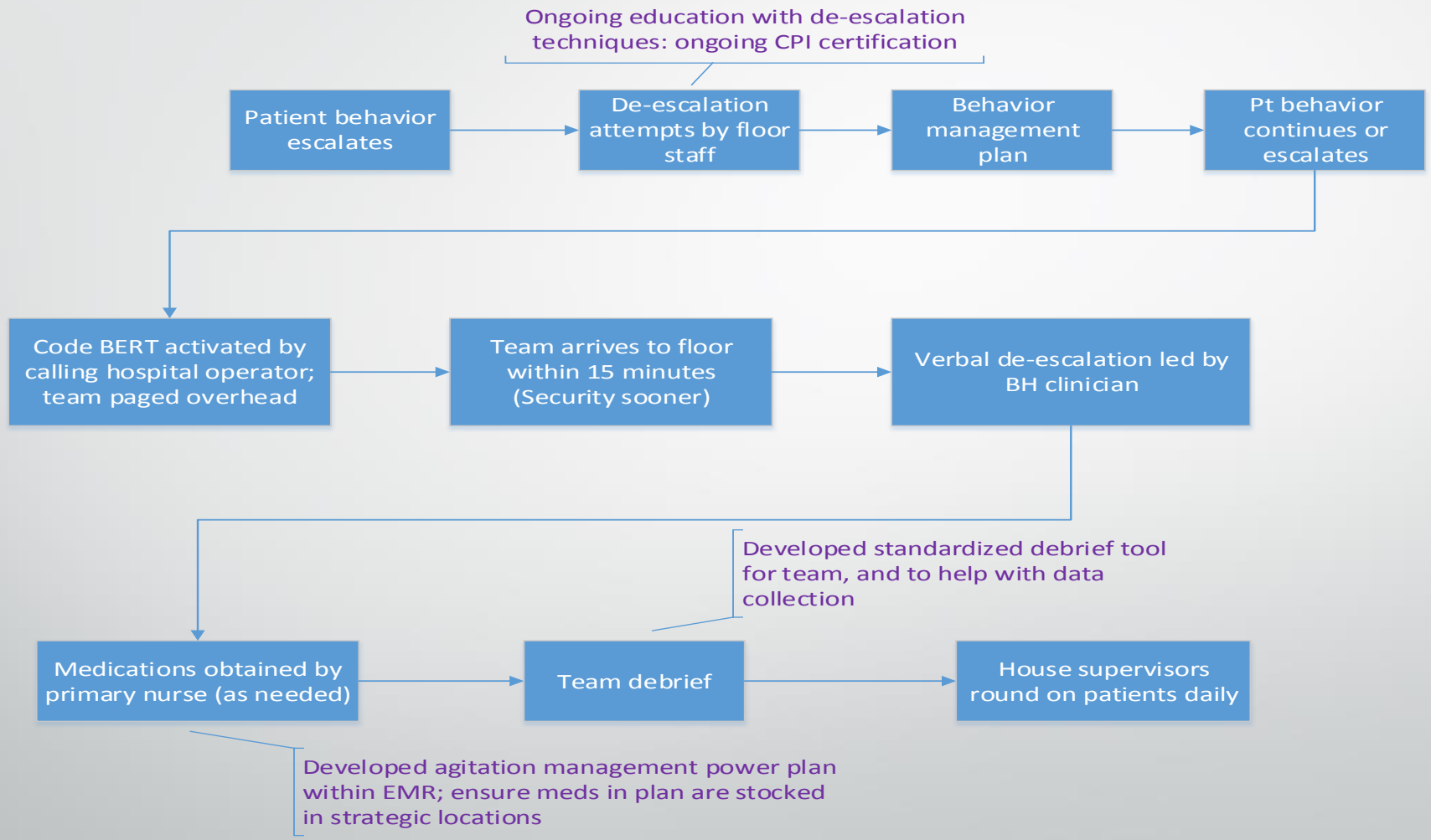
Guiding Principles

- 24/7 availability
- One call
- Immediate response
- Multi-disciplinary team of responders with Behavioral Health and de-escalation expertise
- Continuous development based on feedback & outcome data

Education

- De-escalation
- Restraint Policies and Applications
- Involuntary vs Voluntary
- Activation process
- Responsibilities of each team member
- Drills

Response Process



Unit Staff Debriefing Tool

Complete following each incident of behavioral/crisis management as part of staff processing.
Forward this form to Performance Improvement. Do NOT place in patient chart.

Date: _____ Time: _____ Unit: _____ Patient: _____

Staff members involved:

Describe patient behavior and events resulting in crisis:

If known, describe patient triggers (e.g., length of stay, family, bad news, etc.)

Did patient have a positive ABRAT score? ☐ Yes ☐ No ☐ Not done; if not done, risks for acting out:

- ☐ Previous history of violence
- ☐ Actively hallucinating, psychosis, delirium
- ☐ Under influence of alcohol, chemicals
- ☐ Other: _____

Were there any staff behaviors which may have contributed to patient acting out?

- ☐ Interventions in patient's personal space
- ☐ Body language
- ☐ Voice tone, volume, cadence
- ☐ Power struggle with patient
- ☐ Unrealistic limits or requests
- ☐ Other: _____

Was BRT activated at early stages of escalation? ☐ Yes ☐ No If not, rationale:

- ☐ Pt escalated without warning
- ☐ Did not know about BRT
- ☐ Did not think patient's acting out would escalate further
- ☐ Other: _____

Patient interventions attempted by staff:

- ☐ Calm, soothing voice
- ☐ Limit setting
- ☐ Problem solving w/ pt
- ☐ Decreased stimuli
- ☐ Empathetic listening
- ☐ PRN Medications
- ☐ Isolating the situation
- ☐ Other: _____

Was de-escalation effective? ☐ Yes ☐ No If not, what might be more effective next time?

Did event result in restraints: ☐ None ☐ Therapeutic hold ☐ Violent restraints

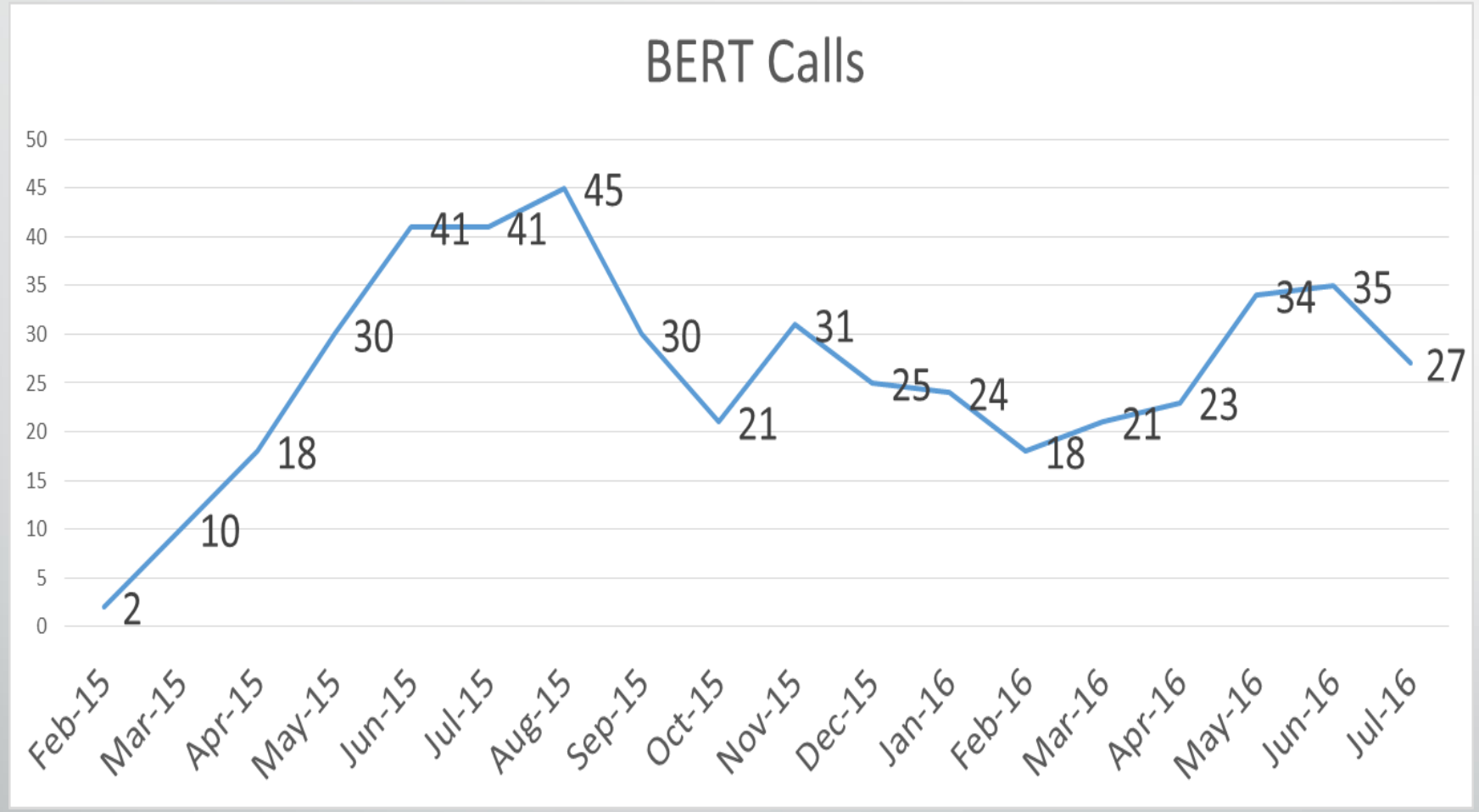
Patient Injuries: ☐ None ☐ _____
Staff Injuries: ☐ None ☐ _____

What went well and why did it go well?

Could anything have been done differently and how could it have been done differently?

Is there any restitution or repair we need to make with the patient?

Did patient debriefing occur? ☐ Yes ☐ No _____


BERT Calls
50
45
40
35
30
25
20
15
10
5
0
2
10
18
30
41
41
45
30
21
31
25
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Feb-15
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Jul-15
Aug-15
Sep-15
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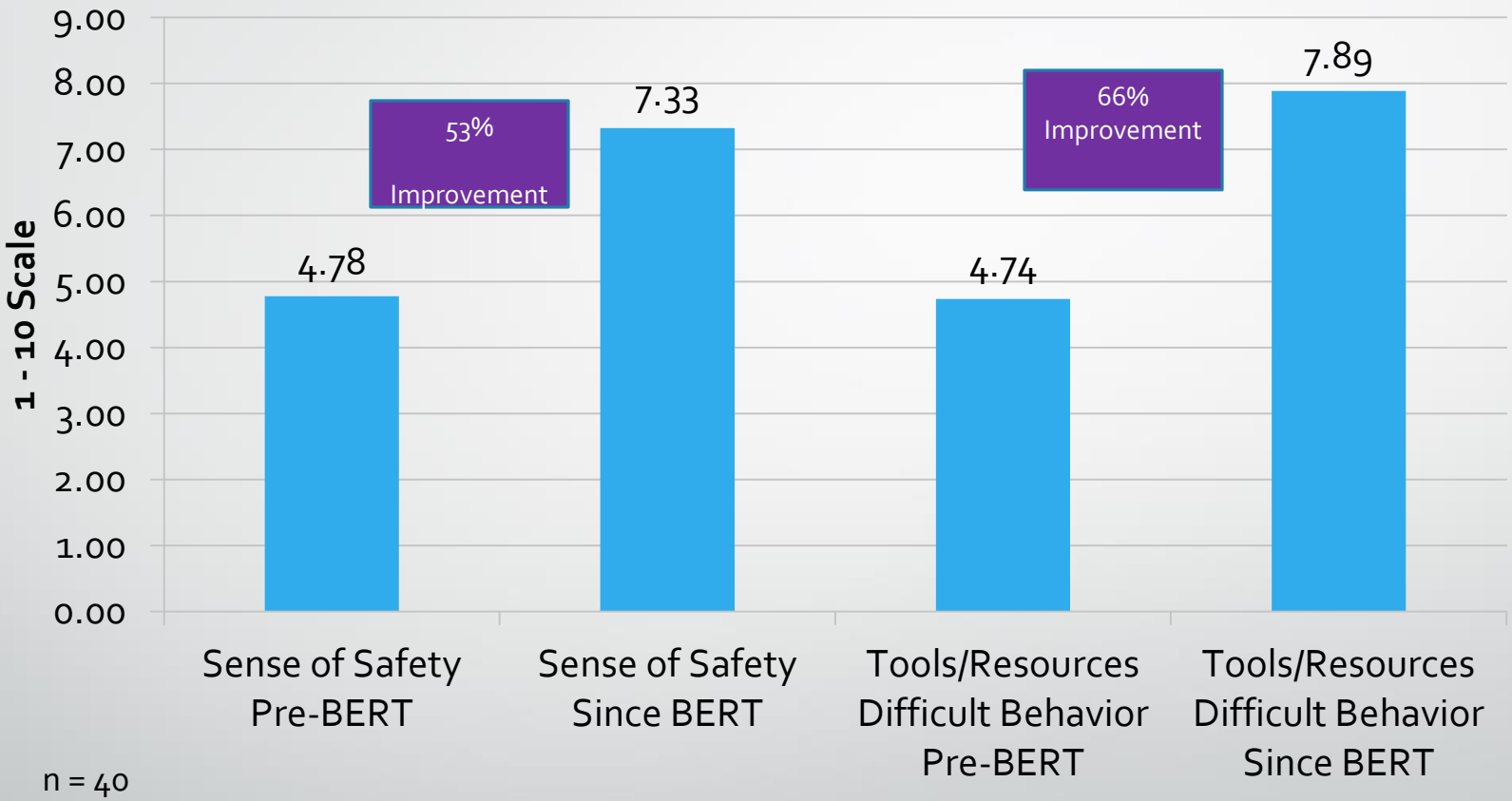
BERT Spot Survey
May 19, 2015



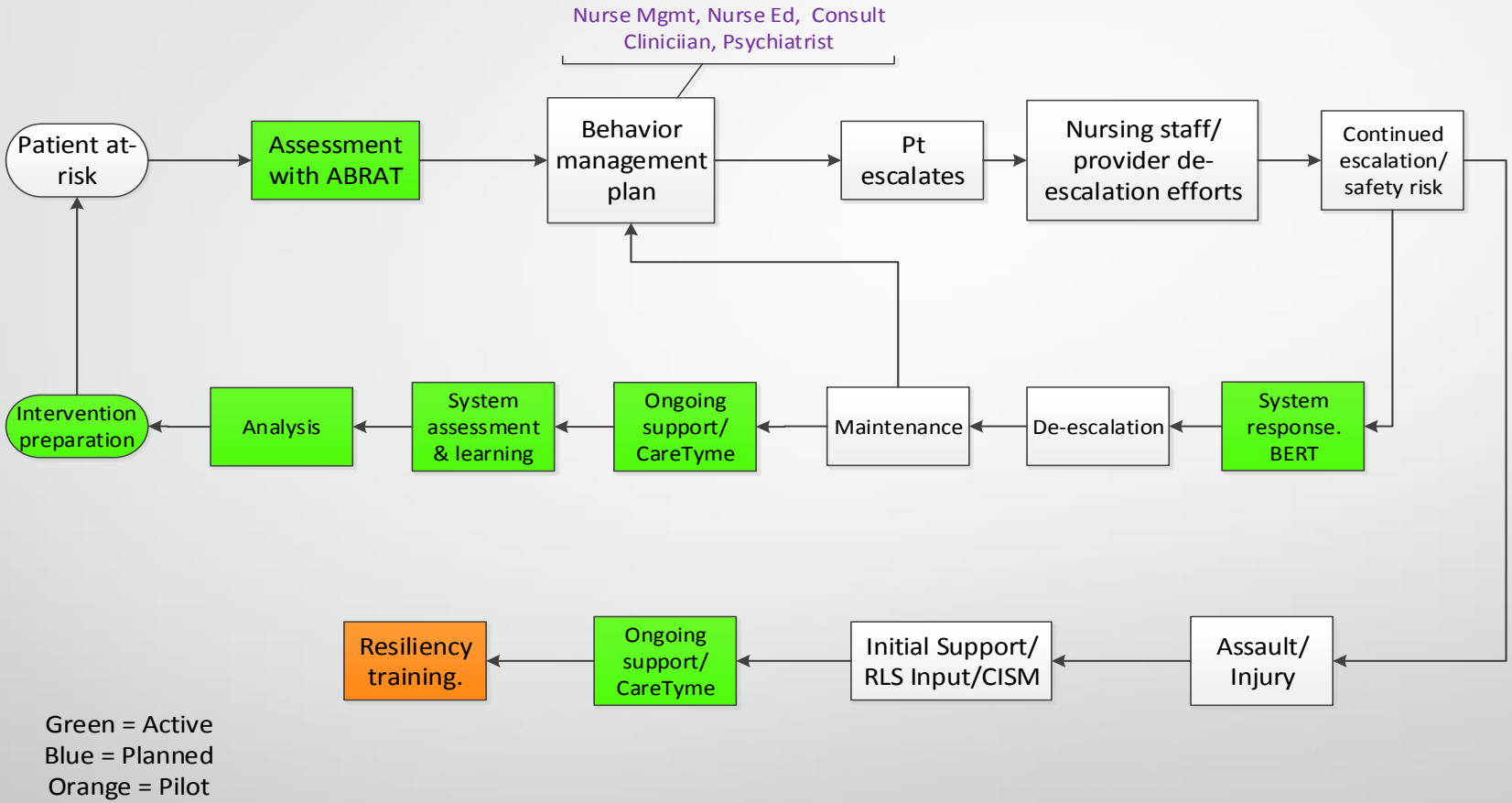
n = 40

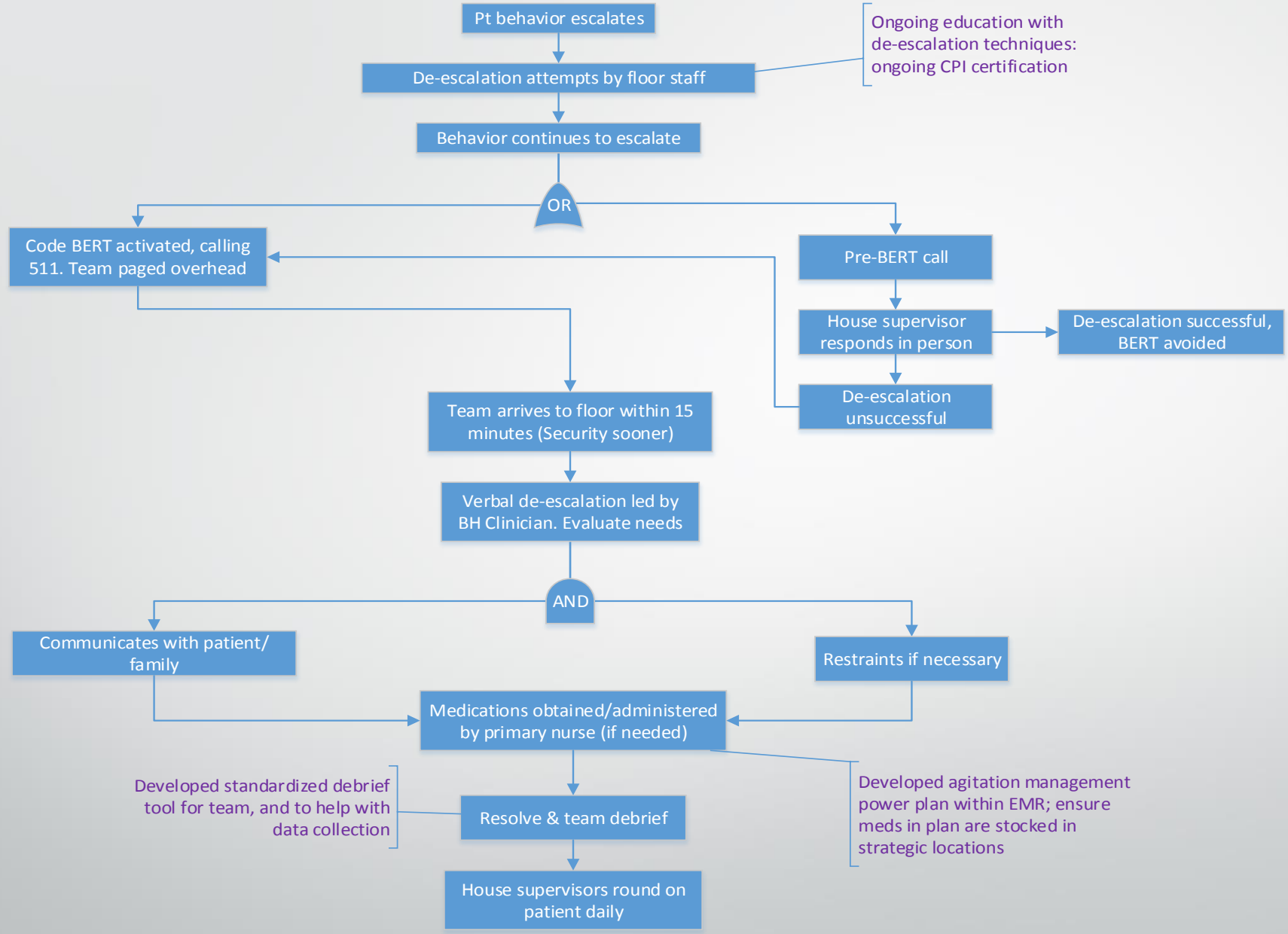
Nursing Survey on 1st Year of Behavioral Emergency Response Team

305 Responses from Nursing Staff, 70% of whom had participated in a BERT call

BERT Survey Monkey	PERCENT				
Survey Questions	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Code BERT has helped me feel safer on my job	3	3	20	45	30
I am pleased with how quickly the BERT team arrives	2	4	11	56	28
Code BERT team is usually effective	2	6	13	48	31
By observing BERT team, my skills at de-escalating are improving	2	9	32	40	17
I feel comfortable working with patients with behavioral emergencies		25		75	

Management of High-Risk Behavioral Health Patients




Pt behavior escalates
De-escalation attempts by floor staff
Ongoing education with de-escalation techniques: ongoing CPI certification
Behavior continues to escalate
OR
Code BERT activated, calling 511. Team paged overhead
Pre-BERT call
House supervisor responds in person
De-escalation successful, BERT avoided
De-escalation unsuccessful
Team arrives to floor within 15 minutes (Security sooner)
Verbal de-escalation led by BH Clinician. Evaluate needs
AND
Communicates with patient/ family
Restraints if necessary
Medications obtained/administered by primary nurse (if needed)
Developed standardized debrief tool for team, and to help with data collection
Resolve & team debrief
Developed agitation management power plan within EMR; ensure meds in plan are stocked in strategic locations
House supervisors round on patient daily

Further Work

- Integrate debriefing tool into EMR
- Assault support process: What happens when there is an assault on staff?
  - Use of administrative leave
  - Critical Incident Stress Management (CISM)
  - Supportive neutrality on pressing charges
- What about the next time?
  - Care recommendations developed by psychiatry for patients with assaultive or violent behavior
  - Electronic flag to alert providers to treatment plan recommendations in subsequent admission

Further Work

- What if they're here for months? Supporting staff caring for behavior problem patients long-term
- But we don't have a clinician 24/7?
  - Developing models that work for smaller hospitals
    - Who do we have that can respond?
    - Training for expert de-escalators?
    - Joint training

Questions