Behavioral Emergency Response Team

Javier Bravo, CHPA
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.

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

Patient behavior escalates

De-escalation attempts by floor staff

Behavior management plan

Pt behavior continues or escalates

Code BERT activated by calling hospital operator; team paged overhead

Team arrives to floor within 15 minutes (Security sooner)

Verbal de-escalation led by BH clinician

Medications obtained by primary nurse (as needed)

Team debrief

Developed standardized debrief tool for team, and to help with data collection

House supervisors round on patients daily

Ongoing education with de-escalation techniques: ongoing CPI certification

Developed agitation management power plan within EMR; ensure meds in plan are stocked in strategic locations
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 □ Under influence of alcohol, chemicals
  □ Actively hallucinating, psychosis, delirium □ Other:

- Were there any staff behaviors which may have contributed to patient acting out?
  □ Interventions in patient’s personal space □ Power struggle with patient
  □ Body language □ Unrealistic limits or requests
  □ Voice tone, volume, cadence □ Other:

- Was BRT activated at early stages of escalation? □ Yes □ No If not, rationale:
  □ Pt escalated without warning □ Did not think patient’s acting out would escalate further
  □ Did not know about BRT □ Other:

Patient interventions attempted by staff:

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

- 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 Spot Survey
May 19, 2015

<table>
<thead>
<tr>
<th>Area</th>
<th>Pre-BERT</th>
<th>Since BERT</th>
<th>Difficult Behavior Pre-BERT</th>
<th>Difficult Behavior Since BERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of Safety</td>
<td>4.78</td>
<td>7.33</td>
<td>4.74</td>
<td>7.89</td>
</tr>
<tr>
<td>Difficult Behavior Tools/Resources</td>
<td>53% Improvement</td>
<td>66% Improvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Survey Questions</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code BERT has helped me feel safer on my job</td>
<td>3</td>
<td>3</td>
<td>20</td>
<td>45</td>
<td>30</td>
</tr>
<tr>
<td>I am pleased with how quickly the BERT team arrives</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>56</td>
<td>28</td>
</tr>
<tr>
<td>Code BERT team is usually effective</td>
<td>2</td>
<td>6</td>
<td>13</td>
<td>48</td>
<td>31</td>
</tr>
<tr>
<td>By observing BERT team, my skills at de-escalating are improving</td>
<td>2</td>
<td>9</td>
<td>32</td>
<td>40</td>
<td>17</td>
</tr>
<tr>
<td>I feel comfortable working with patients with behavioral emergencies</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td>75</td>
</tr>
</tbody>
</table>
Management of High-Risk Behavioral Health Patients

Patient at risk

Assessment with ABRAT

Behavior management plan

Pt escalates

Nursing staff/provider de-escalation efforts

Continued escalation/safety risk

Intervention preparation

Analysis

System assessment & learning

Ongoing support/CareTyme

Maintenance

De-escalation

System response/BERT

Resiliency training

Ongoing support/CareTyme

Initial Support/RLS Input/CISM

Assault/Injury

Green = Active
Blue = Planned
Orange = Pilot

Nurse Mgmt, Nurse Ed, Consult Clinician, Psychiatrist
De-escalation attempts by floor staff

Pt behavior escalates

Behavior continues to escalate

Code BERT activated, calling 511. Team paged overhead

Team arrives to floor within 15 minutes (Security sooner)

Verbal de-escalation led by BH Clinician. Evaluate needs

Communicates with patient/family

Medications obtained/administered by primary nurse (if needed)

Resolve & team debrief

Developed standardized debrief tool for team, and to help with data collection

Developed agitation management power plan within EMR; ensure meds in plan are stocked in strategic locations

Ongoing education with de-escalation techniques: ongoing CPI certification

Pre-BERT call

House supervisor responds in person

De-escalation successful, BERT avoided

De-escalation unsuccessful

Restraints if necessary

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