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Behavioral Emergency Response Team: Implementing a Performance Improvement Strategy to Address Workplace Violence

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Disclosure

- No Conflicts of Interest

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Objectives

- Identify challenges posed by the evolving role of nursing in the current healthcare landscape and strategies that can be used to meet these challenges.
- Review design, purpose, conceptual framework, and results of the Behavioral Emergency Response Team.
- Synthesize components of the principles of de-escalation to non-psychiatric areas to prevent and mitigate aggression in patients and/or family, significant others.

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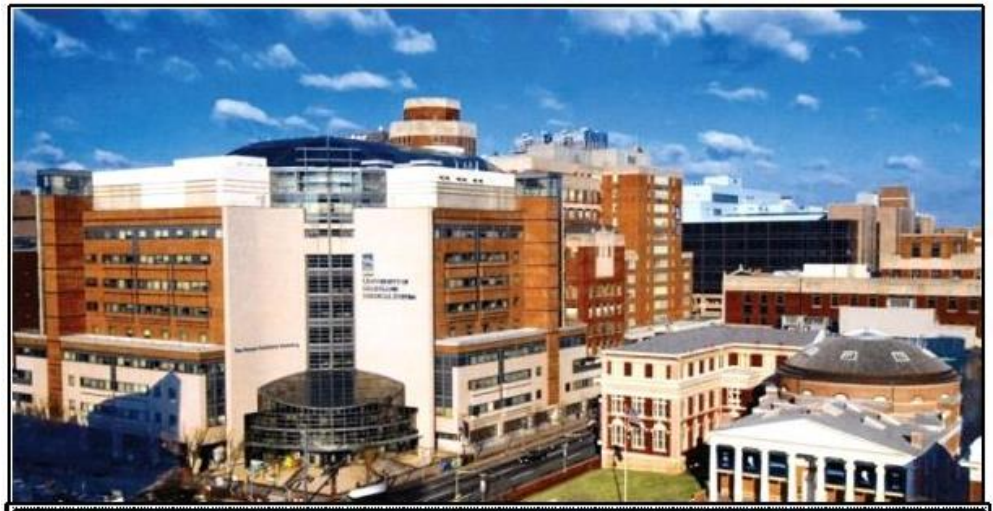
- 816 licensed beds
- 8,011 employees
- 1184 Attending physicians
- 870 Resident physicians
- 35,912 Admissions
- 70,511 Emergency visits
- 8,000 Trauma visits
- 364,118 Outpatient visits
- 23,128 Surgical cases
- 11,207 Maryland Express Care transfer admissions



University Campus

We Heal, We Teach, We Discover, We Care

Workplace Environment

Workplace violence is <u>real</u> and <u>on the rise</u>.

- More assaults occur in healthcare and social services industries than in any other industry.
- There are1.7 million injuries each year due to workplace assaults.
- From 1997 – 2009:
  - 8,127 occupational homicides occurred, of which:
  - 73 were in health services settings, of which:
  - 20 were in hospitals, of which:
  - 12 were physicians and 15 were nurses

(DOL, OSHA, CDC, NIOSH, Bureau of Justice Statistics)

Background

- Senior Executive workplace environmental assessment
- Rebuilding of Security team
- Implement workplace violence prevention and response policy
- Contract with Baltimore City Police
- Technology infrastructure upgrades

Background

- Security Assessment 2011
- Executive formation of two teams 2011
  - Patient/Public Conflict
  - Co-Worker Civility

Background

- Challenging patient situations in clinical areas
- Frequently involve Security, Pastoral Care, Social Work, Psychiatry Consultation & Liaison, Employee Assistance Program & Psychiatry Nurse Manager
- Formal & informal means of communication
- Lacks coordinated, consistent plan of care
- Approximately 50-60 patient interventions per month in FY12

Patient Public Conflict Team

Recommendations

- Develop common workplace violence definitions
- Align mission of employees at entrances
- Mandatory staff education and training
- Panic buttons at all access points
- Create a behavioral emergency response team
- Personal protective alarms

Behavioral Emergency Response Team

A team providing immediate response to a patient or visitor displaying disruptive behaviors that are not life-threatening

Behavioral Response Design Group

- Executive sponsorship
- UMMC multidisciplinary, multi-departmental design team formed
- Discussions focused on current practices, issues, estimated volumes, team members, areas to pilot, definitions, triggers.

Literature and Evidence

- Mental illness affects one in four U.S. adults per year, suicide is the 10th leading cause of death in the U.S.
- Increased awareness of violence in the workplace; has led hospitals to take a closer look at behavioral health issues in the general patient population
- Safety may be compromised when staff not specialized in emergent behavioral situations
- Psychiatric nurses are familiar with behavioral aberrations in patients with mental health issues; observing for predictors of escalation, interventions prior to a negative event, adjusting environments to decrease stimulation & escalation, and reporting signs and symptoms appropriate for potential medication intervention

(Loucks, Rutledge, Hatch, & Morrison, 2010; Pestka, Hatteberg, Zwygart, Cox, & Borgen, 2012)

Literature & Evidence (Con't)

- Behavioral emergency response teams, are consultative resources utilized when psychiatric behaviors present in non-psychiatric settings
- Teams are formed based on availability and practices in each institution, there is no uniform standard of roles to comprise a team
- Target behaviors are generally potentially disruptive or threatening actions of patients who compromise the safety to themselves, other patients, visitors and staff
- Administrative support and prioritization are critical for success

(Ferguson & Leno-Gordon, 2008; Pestka, Hatteberg, Zwygart, Cox, & Borgen, 2012)

Behavioral Emergency Response Team (BERT): A Best Practice

- Team comprised of three core members:
  - -Security Supervisor
  - -Pastoral Care
  - -Psych Emergency Services RN
- Availability 24/7
- LIP paged to respond for consultation
- Ad hoc members include: Psych Consultation Liaison, Social Work, Employee Assistance Program, Patient Advocate, Risk Management, Legal
- 90 day Pilot program rolled out 7/1/13 in Trauma Acute Care & Medical ICU
- Focused on patient and visitor events
- List of easily recognized behavioral triggers identified for staff initiation of calls
- Mechanism for review and evaluation of effectiveness

BERT Goals

- Identify patients that would benefit from a specialized adjunctive support to maximize treatment outcomes and maintain safety
- Provide a coordinated response for difficult and complex patients with disruptive behaviors
- Promote workplace safety, minimizing violent patient events
- Enhance the plan of care for patients with disruptive or threatening behaviors that compromise safety to themselves, other patients, visitors and staff
- Role model communication strategies for de-escalation

Behavioral Triggers for BERT

Behavioral Triggers for Initiation of BERT

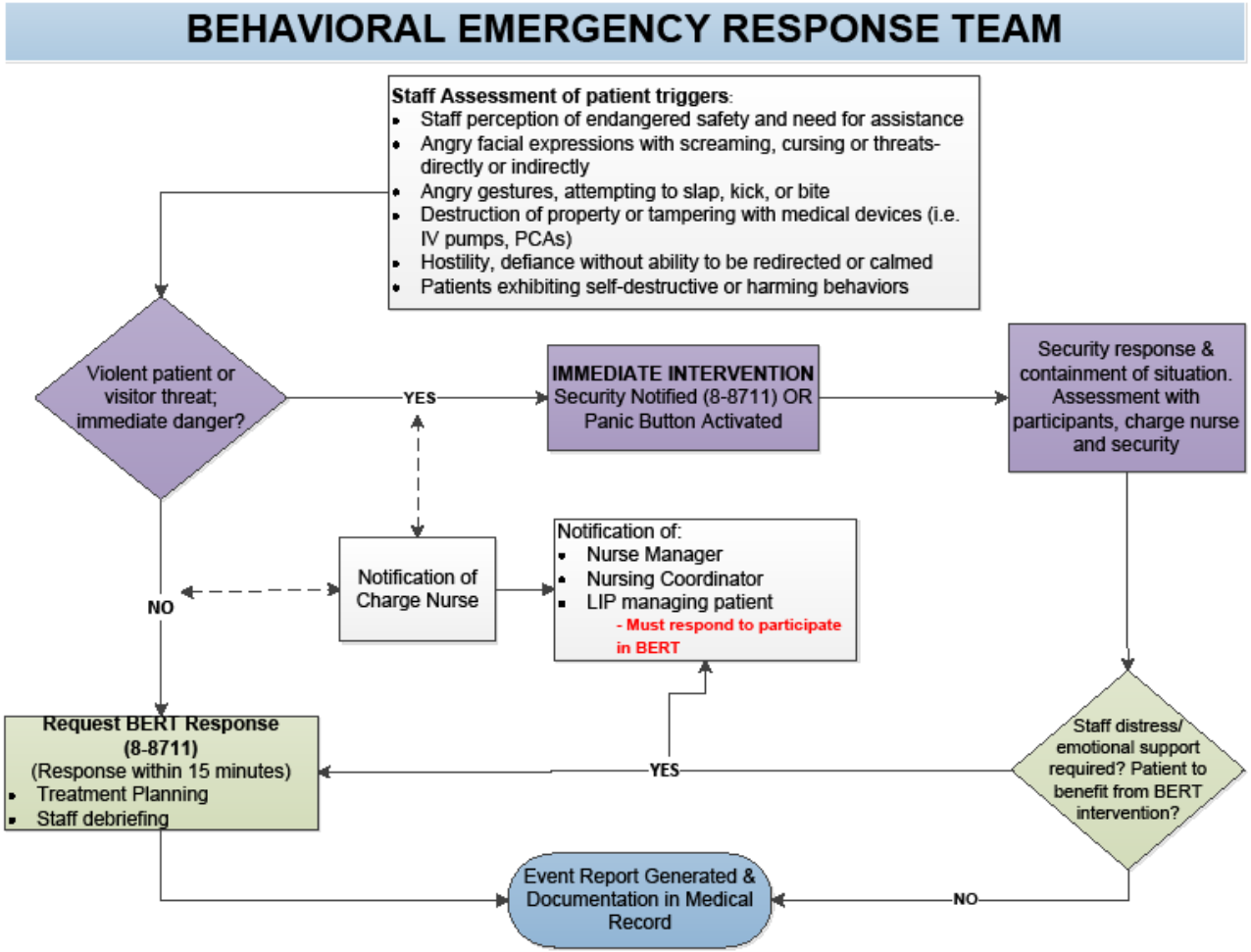
- Staff perception of endangered safety and need for assistance
- Angry facial expressions with- screaming, cursing, words that threaten staff or others, indirectly or directly*
- Angry gestures, attempting to slap, kick or bite*
- Destruction of property or tampering with medical apparatus
- Belligerence- hostility, defiance without the ability to be redirected or calmed*
- Failure to accept medical/nursing recommendations with verbalized intent to harm others or self, deliberately undermining treatment
- Patients who exhibit self destructive or self harming behaviors
- Parents of minor patients with the above behaviors need special consideration

*Especially individuals who have a recent history of violence and aggression, and/or have exhibited anxiety (pacing, staring, irritability)

BERT: Interventions

- Immediate assessment for safety
- Develop rapport with patient to initiate de-escalation
- Communication with physicians and other members of patient's multidisciplinary team to discuss findings and recommendations
- Utilize expertise of ad hoc members as necessary
- Recommend behavioral management plan
- Post event huddle

BERT Algorithm



BERT Response Report

- Initial Assessment
- Interventions: All actions taken by BERT and patient's treatment team
- Identification of triggers
- Post Huddle
- Recommendations

UMMC **Pt ID label**
Behavioral Emergency Response Team
Response Record

Date:_____ Time of Call:_____ Time of Arrival:_____
Length of Team Response:_____
BERT Members:_____
Pt Team Members & LIP_____

Location:_____

Reason for Call:_____
_____

Initial Assessment:_____
_____
_____

Interventions: All actions taken by BERT & Pt's treatment team
_De-escalation _Environment modified _Medicated per team _Pt Agrees to plan
_Identification of triggers _Observation level modified _Tx Plan modified _Integrated into plan of care
_Family/SO meeting _Staff Education _Explanation- Pt code of conduct/expectations
Description/Comments:
_____
_____
_____
_____
_____
_____
_____
Staff Post Huddle: Individual/Group(circle) _____
_____
Recommendations, Areas for F/U:
_____
_____
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_____
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_____
_____

Signatures:_____

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Financial Considerations

- Utilizes existing resources without additional requests for FTE and other support resources
- Subsequently have implemented BERT to all medical units and to the pediatric areas

Initial Evaluation

Several emerging themes identified during pilot phase:

1) Refusal of care and/or leave AMA

2) Patient's perceptions of not being listened to or not being respected

3) Multidisciplinary team needs, everyone knowing plans/roles/expectations

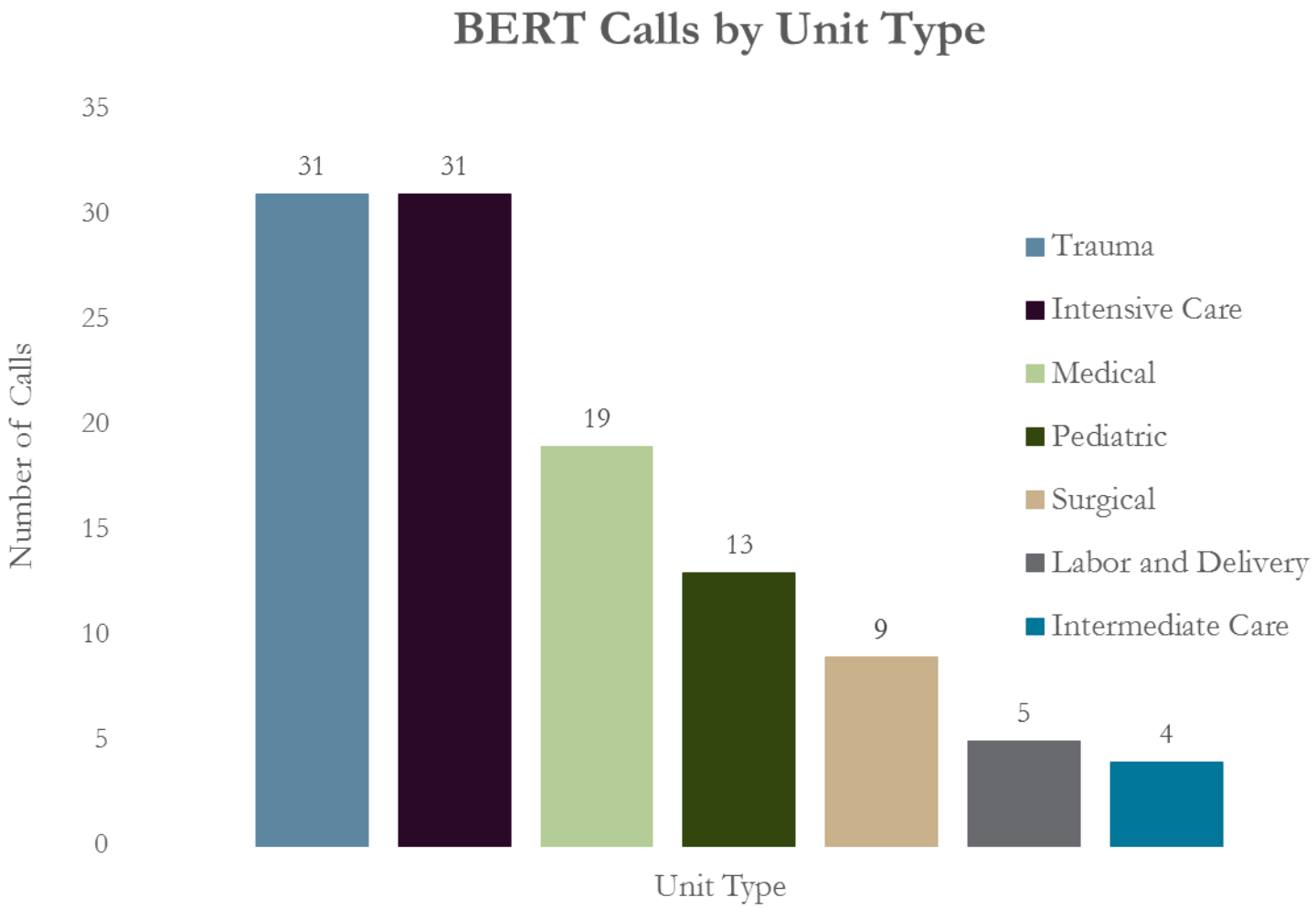
4) Patient & visitor disruption

Evaluation of Pilot

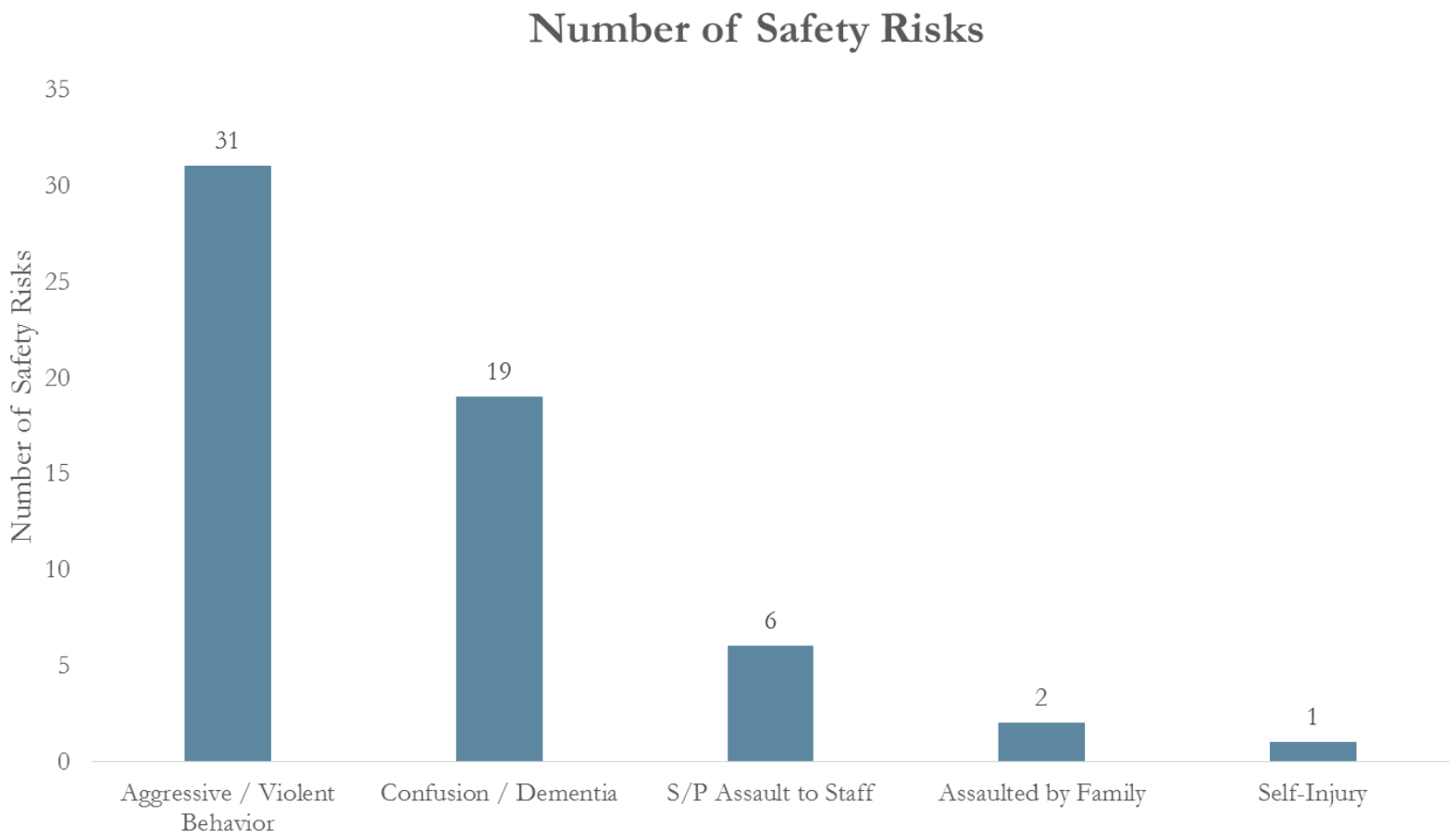
Staff Education needs identified:

- Capacity for decision making-multidisciplinary need
- Reinforcement of de-escalation, not personalizing negativity
- Restraints: use, policy requirements, application, removal

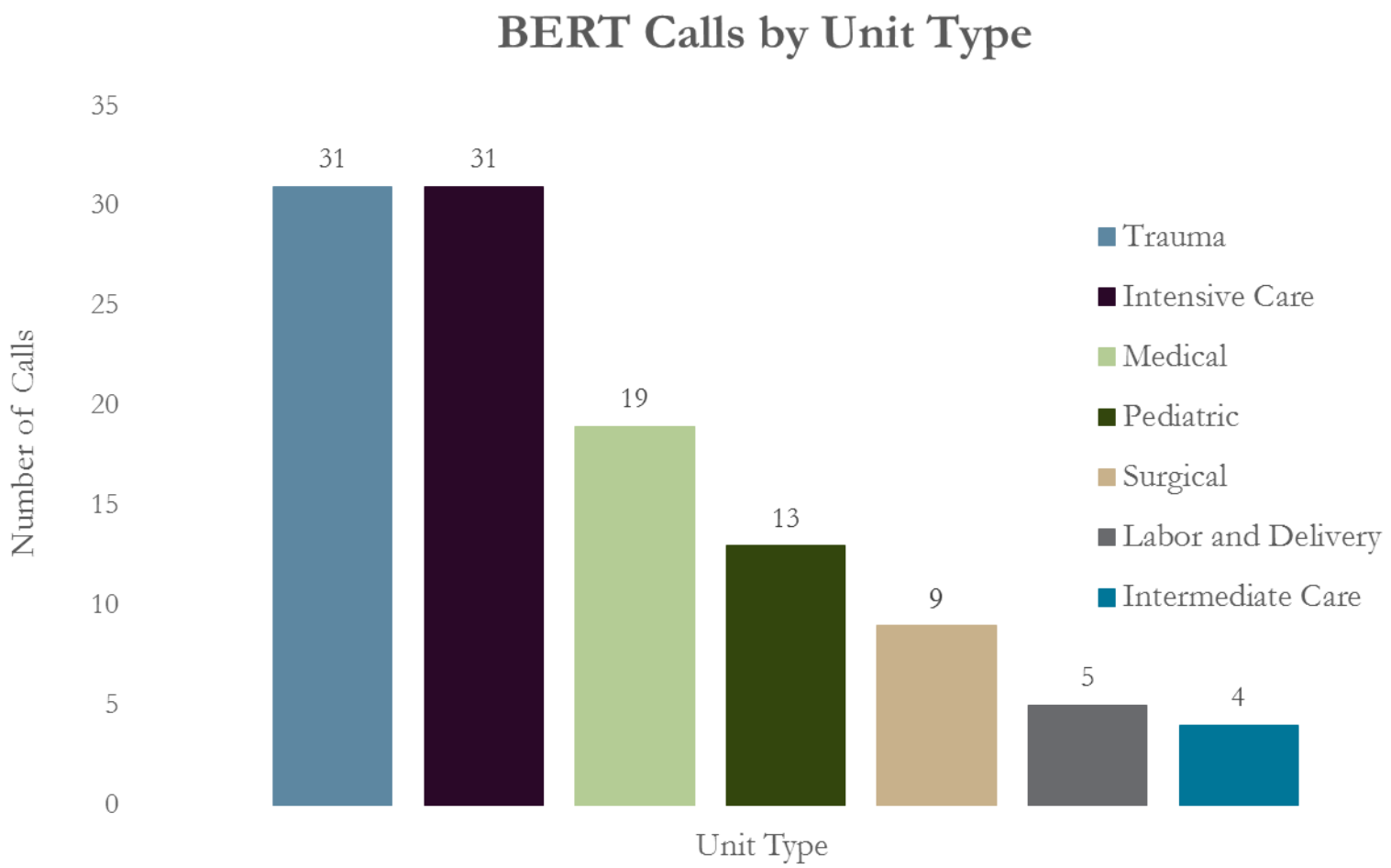
Results 2017



Results 2017



Results 2017



Questions?

Thanks for the opportunity to present

Questions?

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