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.
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

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Workplace Environment

Workplace violence is **real** and **on the rise**.

- More assaults occur in healthcare and social services industries than in any other industry.

- There are 1.7 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.
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)
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

BEHAVIORAL EMERGENCY RESPONSE TEAM

Staff Assessment of patient triggers:
- Staff perception of endangered safety and need for assistance
- Angry facial expressions with screaming, cursing or threats—directly or indirectly
- Angry gestures, attempting to slap, kick, or bite
- Destruction of property or tampering with medical devices (i.e. IV pumps, PCAs)
- Hostility, defiance without ability to be redirected or calmed
- Patients exhibiting self-destructive or harming behaviors

Violent patient or visitor threat; immediate danger?

NO

YES

Immediate Intervention
Security Notified (8-8711) OR Panic Button Activated

Notification of Charge Nurse

Notification of:
- Nurse Manager
- Nursing Coordinator
- LIP managing patient
  - Must respond to participate in BERT

Request BERT Response (8-8711)
(Response within 15 minutes)
- Treatment Planning
- Staff debriefing

Event Report Generated & Documentation in Medical Record

Security response & containment of situation. Assessment with participants, charge nurse and security

Staff distress/emotional support required? Patient to benefit from BERT intervention?

NO

YES
BERT Response Report

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

BERT Calls by Unit Type

- Trauma: 31 calls
- Intensive Care: 31 calls
- Medical: 19 calls
- Pediatric: 13 calls
- Surgical: 9 calls
- Labor and Delivery: 5 calls
- Intermediate Care: 4 calls
Results 2017

Number of Safety Risks

- Aggressive / Violent Behavior: 31
- Confusion / Dementia: 19
- S/P Assault to Staff: 6
- Assaulted by Family: 2
- Self-Injury: 1
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Thanks for the opportunity to present

Questions?


