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

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Disclosure

• The speakers have no conflicts of interest to disclose

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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 including administrative commitment.

• Review design, purpose, conceptual framework, and one year results of the Behavioral Emergency Response Team (BERT).

• Synthesize components of the principles of de-escalation to non-psychiatric areas to prevent and mitigate aggression in patients &/or family significant others.

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Violence in Healthcare

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)
Violence in Baltimore City: The Good News

FBI - Crime Rates in U.S. Cities 2010

Baltimore City is in the top 10 cities with the highest crime rates per 100,000 residents

- Flint, MI 827.0
- Lubbock, TX 808.3
- Pine Bluff, AR 793.0
- Las Vegas, NV 763.4
- Little Rock, AR 755.8
- Baltimore, MD 685.3
- Wilmington, DE 634.8
- Philadelphia, PA 551.8
- New York, NY 496.0
- New Orleans, LA 466.5

(These are not the top ten, just examples and comparisons with Baltimore)

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
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, have yielded specifics on creating a Behavioral Emergency Response Team at UMMC

Literature and Evidence

- Increased awareness of violence in the workplace; has led hospitals to take a closer look at behavioral health issues in the general patient population
- Mental illness affects one in four U.S. adults per year, suicide is the 10th leading cause of death in the U.S.
- 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, Ziggy, 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 & Lena-Gordon, 2008; Pestka, Hatteberg, Ziggy, 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 will also be 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

**BERT Algorithm**
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 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
- We have subsequently 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
**FY 2014 Data**

- Total calls - 95
- Reasons for calls - top 4
  - Patient agitation
  - Family member being upset
  - AMA (Against Medical Advice) requests
  - Patient agitated & threatening to staff
- Average intervention time 34 minutes

**Characteristics of BERT Calls**

![Type of Call and Average Time Spent at Event]

- Patient agitation
- Family member upset
- AMA (Against Medical Advice)
- Patient agitated & threatening to staff

**Reasons for BERT Requests**

![Root Cause of BERT Call]
Actions of the BERT team

Security Data

Total number of calls to Security for Combative Patients
- 47% decrease from FY12 to FY14
- 6% decrease from FY13 to FY14

Security Data

Total number of calls to Security for Panic Alarms
- 39.7% increase from FY12 to FY14
- Increased awareness of staff to request assistance
- Multiple reasons for panic alarm—not just agitated patients
- Combined total calls - 4.1% overall decrease
Next Steps

• Expansion to all medical center units in this fiscal year, currently BERT roll out is 12/52 units
• Addition of Complementary Medicine techniques for staff support and stress management (Aromatherapy and Breathing techniques)
• Comparison with rates staff injury/lost days worked
• Continue to address root cause issues contributing to patient agitation systemically

Questions?

Thanks for the opportunity to present

Questions?

References


