

Enhancing Safety in Behavioral Emergency Situations

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Nurses in non-psychiatric settings frequently are expected to provide care to patients with mental health and behavior management issues. One in four American adults suffers from a diagnosable mental disorder in a given year, with 1 in 17 suffering from a serious mental illness (National Institute of Mental Health, 2010). In a review of the literature, Zolnieriek (2009) noted several studies suggesting people with mental illnesses experience increased medical comorbidities often necessitating hospitalization. A study by Berren, Santiago, Zent, and Carbone (1999) indicated individuals with a mental illness tend to receive care more frequently in urgent/acute care settings than persons without a mental illness.

Multiple factors influence nurses' abilities to provide effective interventions to patients with mental health issues in non-psychiatric inpatient settings. Two factors, the presence of negative attitudes toward patients with mental illnesses along with nurses' perceptions of a lack of competence and confidence in identifying and managing behavioral symptoms, have been cited in a variety of publications (Brinn, 2000; Reed & Fitzgerald, 2005; Ross & Goldner, 2009; Sharrock & Happell, 2006; Zolnieriek, 2009). Further compounding nurses' fear and lack of confidence, patients with mental illness often are perceived as unpredictable and dangerous (Ross & Goldner, 2009).

Workplace violence is a real concern. Occupational Safety and Health Administration's (OSHA, 2004) workplace violence prevention guidelines

The implementation of a behavioral emergency response team (BERT) at a large midwestern health care organization is described. The BERT is a resource supporting nurses and other health care staff in managing behavioral emergencies. The Joint Commission (2010) reported an increasing rate of violence by patients toward health care staff, reinforcing a need for the BERT. No published reports were found in the literature of a BERT utilizing multidisciplinary mental health experts and security officers as responders. Development strategies, response data, and outcomes of this successful initiative are highlighted.

indicate health care workers face a significant risk of job-related violence. OSHA guidelines state that "lack of staff training in recognizing and managing escalating hostile and assaultive behaviors" places health care workers at higher risk for work-related assaults (p. 7). In the executive summary of the American Psychiatric Nurses Association (APNA, 2008) Position Statement, the authors offer a broad definition of workplace violence to include "physical, sexual, and verbal threats and abuse from peers as well as consumers" (p. 1). The APNA recommends health organizations establish comprehensive programs to prevent and manage workplace violence.

The actual number of health care worker injuries related to assaults by patients is unknown. Violence

against nurses may be underreported for a variety of reasons including the view that it is part of the job (APNA, 2008; Roche, Diers, Duffield, & Catling-Paull, 2009). In a summary of the literature, Roche and colleagues (2009) cited that beyond the possible immediate injury, the effects of instances of workplace violence can spread distress among staff members, and lead to increased nurse turnover and deterioration in staff health. A recent Sentinel Event Alert from The Joint Commission (2010) identified the need for hospitals to reduce the risk of violence to staff as there are increasing rates of reported violence including assaults by patients.

Various solutions have been offered by experts to address nurses' fears, and improve staff safety and

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patient outcomes when caring for patients with behavioral issues in non-psychiatric settings. These recommendations include additional nursing education, increased nursing exposure to patients with mental health issues, and implementation of consultative liaison services or specialized care units (Atkin, Holmes, & Martin, 2005; Zolnierak, 2009).

Another solution includes use of a team response, modeled after medical rapid response teams (RRTs), which are adapted for mental health and behavioral needs. Rapid response teams have been introduced in the United States as a resource to bring specialized expertise to a patient's bedside to intervene earlier and prevent a patient's physiological deterioration (Donaldson, Shapiro, Scott, Foley, & Spetz, 2009; Hatler et al., 2009; Scott & Elliott, 2009; Wynn, Engelke, & Swanson, 2009). Only one team model was found in the literature for responding to behavioral issues needing emergent attention comparable to a RRT. This behavioral emergency response team (BERT) was developed successfully and implemented to bring resources and skills to the bedside to assist in managing patients' "disruptive or threatening actions" and "risky or scary behaviors" (Loucks, Rutledge, Hatch, & Morrison, 2010, p. 94). Loucks and co-authors' behavioral response team is a consultative resource consisting of on-duty registered nurses and social workers with experience in managing acute psychiatric disorders and assaultive behaviors. Nurses in non-psychiatric areas activate the resource based on established patient criteria, with one or more team members responding. BERT members provide assessment and intervention to de-escalate or intervene in cases of problematic behaviors or symptoms, role model interventions, debrief with unit staff, and provide one on one education.

The setting for the BERT discussed in this article is a large tertiary care hospital affiliated with a medical center in the midwestern United States. This BERT is similar in numerous ways to the innovative team that Loucks and colleagues (2010) described. Unlike the BERT, however,

this response team includes psychiatric physicians and nurses as well as security officers and data collection from several customized forms.

Development of a Behavioral Emergency Response Team (BERT)

The initial idea of developing a BERT as a resource for managing behavioral emergencies in non-psychiatric areas at the authors' medical center was prompted by a staff nurse on an inpatient medical unit. She attended a national nursing conference focused on patient safety. During discussion at one session, another conference participant shared her institution's emergency strategy that alerts designated responders of the need to assist with managing violent situations in the hospital. This was the spark that ignited discussion about developing a similar resource in the authors' workplace.

The organization recognizes safety as a top priority in providing care. Safety may be compromised when staff not specialized in dealing with emergent behavioral situations are required to make difficult assessments and interventions. Providers in medical and surgical areas are challenged environmentally as they do not have locked units or areas tailored for de-escalation of potentially unsafe behaviors. Leaders of non-psychiatric units reported experiencing increasingly complex psychiatric and behavioral patient management issues such as behavioral dyscontrol related to mental illnesses, dementia, traumatic brain injuries, withdrawal from alcohol and drugs, situational coping, and very agitated delirium, including hallucinations and delusions.

A planning and oversight group began meeting to discuss the feasibility and opportunities for a BERT. The workgroup included the medical registered nurse who brought the idea forward, a medical nurse manager, a psychiatric clinical nurse specialist, two nurse administrators, and the manager of security, with input from the psychiatric resident group and

several pharmacists. There was enthusiastic commitment from all members of the oversight group to implement a pilot team as soon as possible, which was achieved within 4 months of the first meeting. The goal was to provide a team of multidisciplinary expert staff prepared to manage psychiatric issues and disruptive behaviors by providing brief interventions to help manage emergent situations for patients, family members, and care providers in areas outside psychiatric units.

Following several oversight workgroup meetings, the BERT pilot program was initiated. The initial implementation of the BERT pilot occurred in November 2008 on six general medical inpatient units. These units were selected given the number of patients hospitalized with co-morbid psychiatric conditions, staff requests for resources to assist in managing behavioral issues, and ongoing discussion about the need for a separate patient care unit for complex patients with medical needs and concurrent behavioral or mental health issues. Ten months following the BERT implementation on the six original units, response data were analyzed and the team expanded coverage to three additional inpatient units. Immediate further expansion was not part of the oversight group's plans; however, nurses float between units in the large hospital, and the BERT was perceived as such a valuable resource that the team received calls from additional units for assistance. The BERT now has expanded to respond to calls and assist with emergent behaviors on all units in two hospitals. In the past year, an average of 40 calls have been received per month. Even though the number of involved units expanded considerably, the number of calls did not increase correspondingly. There is no specific cause and effect relationship, but it is likely that learning from the BERT responses reduced reactive need for assistance, and the BERT is serving as a proactive resource.

The BERT includes collaborative responsibilities of a psychiatric registered nurse, psychiatric physician, and at least one security officer. The

psychiatric nurse serves as team leader, assesses and recommends interventions, and assists with developing a plan of care for managing a patient's behavioral needs. The nurse facilitates debriefing following a BERT response and completes a follow-up telephone call to the unit within 4 hours of the event to assess the effectiveness of the interventions. If the responding RN identifies a need for physician input, the psychiatrist carrying the BERT pager is contacted to assess patient needs. The psychiatrist may recommend emergent psychiatric medications as well as a transfer to a psychiatric unit if warranted. If unable to respond in person, the psychiatrist will review the identified patient's electronic record, discuss the case with the primary provider via telephone, and make recommendations as needed. Security officers help de-escalate a situation and provide hands-on assistance to manage behaviors safely. Many times, the presence of officers in uniform is helpful in calming a situation.

Education for each of the responding disciplines was an important step to ensure understanding of the rationale and goals for initiating the team and assigned roles. Initially, most of the psychiatric nurses at the medical center were assigned shifts to respond to BERT calls. They attended classroom sessions and accessed online information to inform them of their roles and responsibilities with the BERT. These psychiatric nurses also received ongoing staff and patient safety training as part of their orientation, with annual competencies that emphasized verbal crisis intervention techniques and methods for redirecting activities of an individual exhibiting potentially assaultive behavior. In 2011, six psychiatric nurses were selected for consistency in BERT coverage. They received focused education on responding to behavioral emergent events, including opportunities to practice team responses to situations in a simulation center.

The psychiatrists were provided an overview of their duties related to the BERT at a monthly meeting and

via web materials. Ongoing dialogue at meetings helped to answer questions and clarify their evolving role. Security officers were trained by their manager, who is a member of the BERT oversight group, at regularly scheduled training sessions. Training emphasized that security officers would continue to respond to all staff requests for assistance as before; now, as part of a specialized team, they would be able to collaborate on emergent behavioral interventions.

An education plan also was implemented for staff on the calling units to facilitate an understanding of the BERT as a new resource to help manage behavioral situations. Multiple brief educational sessions were held on each unit for all three shifts. Nurses were given a tri-fold pocket card explaining the purpose, calling criteria, and process for calling the BERT. Physicians, advanced practice nurses, and physician assistants also were provided with brief education about the BERT so they could understand how to collaborate and utilize the team.

Activation, or calling criteria, for the BERT include:

- A staff member is worried about the patient's behavior
- Threats or perceived threats against self, another person, or property
- Sexual threats/issues/assaults and/or any other unwanted physical contact (spitting, intentional exposure by patient to bodily fluids)
- Concerns about behaviors related to placement of a 72-hour (involuntary) hold
- Disruptive behavior upsetting unit function.

When a need for the BERT is determined, any staff member can activate the team by internally calling 911, requesting the BERT, and providing information related to the caller and location of the behavioral situation. The telephone operator will contact the responders. A patient's primary provider also is notified of the situation and responds to collaborate with the BERT.

The person requesting the BERT's assistance remains available for com-

munication and continuity of care. BERT responders assess the situation and collaborate with nurses, physicians, and other staff from the requesting unit to resolve the emergent behavioral episode. A variety of interventions are used, such as verbal communication, calming techniques, environmental changes, medications, recommending an individual assignment, and as a last resort, restraints. Once the behavioral emergency is resolved, a debriefing assists the group to review the situation, and discuss what worked well and other strategies that might have been used. It is also a time to ask questions and validate emotional reactions to unusual, violent, or out-of-control behaviors. Staff appreciate the opportunity to debrief regarding stressful episodes of care. A follow-up contact from a BERT nurse responder within 4 hours helps to ensure the incident was resolved successfully and the plan of care is effective. Additional recommendations may be provided at this time, depending on the patient's condition and situation.

Because the RRT at this institution had been in existence for 2 years prior to initial BERT implementation and was utilizing data collection forms effectively, the BERT Planning and Oversight Group decided to modify the RRT forms for behavioral emergency situations. The first form gathers data related to the actual response, including caller, date, time of day, location, and length of response. The form also requests situation, background, assessment, and recommendation (SBAR) information from the response team as well as interventions the team provided. The second form, a continuous improvement form, focuses on evaluation of the process and learning needs, and the responder's assessment of satisfaction with the call. The third form is designed to collect information from the person calling for the BERT as to his or her satisfaction and feedback regarding the BERT response. Feedback is reviewed and addressed by the oversight group for continuous improvement.

Data from the BERT's Responses

Following each BERT request for assistance, data for each team response are collected using the forms developed for the team as well as a separate security report. The information from the response forms is entered into a spreadsheet and monthly reports, including information for that month as well as cumulative data, are shared with the team's responders and users.

The BERT is available around the clock, with 39% of calls made during the day shift, 39% on evenings, and 21% on nights. Calls are distributed evenly throughout the week. The length of BERT responses has ranged from 5 minutes to 220 minutes, with an average of 43.5 minutes on site addressing an emergent need.

Review of the data identified some early trends in reasons for BERT assistance. The most frequent reason for calling the BERT was hyperactive delirium, including delusions and hallucinations. The underlying cause of patients' delirium included medication reactions, fluid and electrolyte imbalances, infections, pain, and sleep deprivation; frequently, multiple factors were contributory. Identification of delirium as a significant factor in behavioral emergency situations was informative because it is a medical condition with behavioral implications. This allowed increased focus on early assessment and management of delirium symptoms and causes.

Initially, the second and third most frequently identified reasons for calling the BERT were challenging behaviors related to alcohol and nicotine withdrawal. Team interventions facilitated immediate response to behaviors, and then proactively treating underlying alcohol and nicotine withdrawal needs. Other notable reasons for BERT calls included psychosis unrelated to delirium, reported active suicidal thinking and/or plans, and disruptive personality disorder behaviors.

As the most frequent factors precipitating a BERT call were identified, team responders requested a

flow diagram to guide them on behaviors most often exhibited with recommended emergent interventions (see Figure 1). In some instances, the BERT has collaborated with the primary provider to establish a patient's capacity to make a decision to leave the hospital against medical advice, as long as the patient's situation did not pose safety risks for his or her well-being or that of others. Having the BERT assist with this process has been valuable.

Unexpectedly, the majority of early BERT calls were not associated with psychiatric or mental health diagnoses but rather emergent behaviors precipitated by medical conditions, such as delirium and alcohol withdrawal. In the first 2 years, 19% of requests for assistance reported an assault by a patient on a nurse or patient care assistant. These assaults were by patients who hit, scratched, bit, or threw materials at a health care staff person. Authors believe it is important to capture data related to these incidents to examine circumstances in which these safety risks are occurring. Analysis of the BERT data and related changes to enhance safety supports the national directives by OSHA, The Joint Commission, and APNA to implement resources to reduce the risk of violence to staff. Incidence of reported assaults has declined considerably to 2%; however, some variation may result from the interpretation and inclusiveness of assaultive behavior.

The most frequent team intervention is verbal interaction with the patient, which has been used in 75% of responses; calming techniques used 48% of the time; and a focus on destimulating the patient's environment, which includes reducing lighting, noise, equipment, and the number of people immediately in the setting. Often soothing music via available television/audio capability in each room is used. Sometimes distraction and reminiscence interventions are effective in helping to orient and refocus a patient.

Having a psychiatrist as a member of the BERT has proven to be very important. In 53% of the cases, a

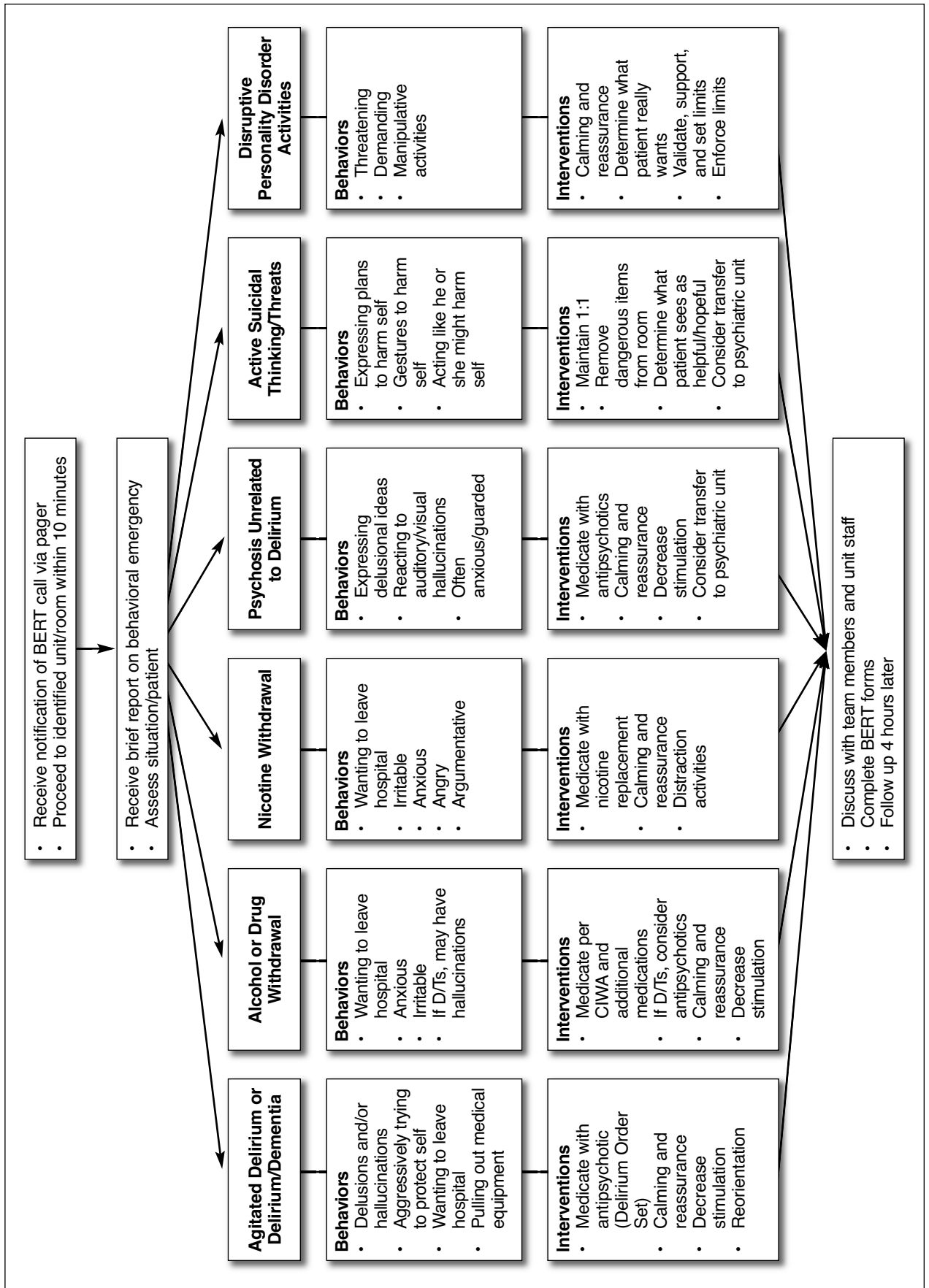
recommendation for initiation or dosage adjustment of medication for behavioral management has helped to resolve the situation. The physician member of BERT does not order the medication but makes expert recommendations to the primary provider.

Role modeling performed by the psychiatric nurses, security officers, and physicians on the BERT responding to behavioral emergency situations has been valuable. It allows non-mental health professionals an opportunity to see how staff members who frequently confront these types of behaviors react and manage situations. Authors believe discussing a behavioral emergency following the episode has helped develop a better understanding of situations and interventions. The BERT indicates the team's interventions in 99% of the cases were effective immediately following the response and were still effective 4 hours later.

Data identifying the reasons for behavioral emergencies have allowed for discussion and planning to provide targeted education and practice changes. A number of formal and informal venues have been utilized to share findings from the BERT and identify proactive interventions. An ongoing practice change has included a greater awareness of assessing, diagnosing, and treating symptoms of acute delirium. Another change is a focus on identifying patients with a history of alcohol abuse or dependence which suggests a need for more, or different, withdrawal medication than indicated by the typical Clinical Institute Withdrawal Assessment (CIWA) order set. Nurses assigned to the BERT now proactively use a database to identify hospitalized patients who are being managed with the CIWA, and review their situations and make recommendations. More aggressive efforts have been made to ensure all patients with a history of cigarette smoking are administered nicotine replacement while in the hospital.

Practice changes linked to BERT are evolving. The number of calls for assistance has not increased a great

FIGURE 1.
Behavioral Emergency Response Team (BERT) Flow Diagram



deal despite including many additional units for BERT coverage. The percentage of calls for agitated delirium and alcohol and nicotine withdrawal has decreased from the highest level in the second quarter of 2009. By gathering and using data related to the reasons precipitating behavioral emergency situations, and providing targeted education and recommended practice changes, authors believe the culture of providing care has changed to enhance safety for both patients and providers.

Strengths of the BERT

This team took a proposed solution to a long-standing problem, brought forth by a nurse engaged in direct patient care, and developed it into a valuable resource for patient and staff safety. In addition to enhancing safety, the BERT also has contributed to nurses' satisfaction with their work. Many nurses have commented on the validation in knowing their request for assistance with managing behaviorally emergent situations is being addressed. Nurses and patient care assistants frequently state they feel safer knowing they have a resource to assist them with escalating patient behaviors. Psychiatric nurses report satisfaction with the affirmation of their specialty skills by their non-psychiatric peers following interventions with challenging behavioral patient situations. The BERT also is associated with broader collaborative efforts between psychiatry and medical and surgical areas in all disciplines.

Having a highly functional medical RRT provided an important blueprint for a team focused on behavioral emergencies. The calling method, data collection forms, and team format were replicated with modifications for the BERT. All staff were familiar with the concept of an emergency response team for medical needs, so providing education for the BERT was considerably easier.

Key factors related to the success of this project include collection of data from the calls to guide education and practice initiatives. Qualitative data from a number of disciplines has

TABLE 1.
Staff Responses to the Behavioral Emergency Response Team

<p>Nurse Requesting BERT Response</p> <p>"Just wanted to let you know that I love BERT! I had to call for it on evening shift last night after my patient got very violent and agitated. I called for BERT immediately and felt much supported during the entire episode. (The patient's doctor) also expressed his appreciation for the team as he had just come on (duty) covering this patient when the event started. Good idea ... something much needed in the medical setting."</p>
<p>Nurse Providing BERT Response</p> <p>"I didn't realize how difficult it is to care for agitated patients on an unlocked unit. I can understand how assistance of the BERT is important."</p>
<p>Security Office Providing BERT Response</p> <p>"Being able to help manage these behavioral situations with an expert multidisciplinary approach improves the quality and safety of the entire health care environment."</p>
<p>Psychiatrist Providing BERT Response</p> <p>"The BERT is a great way to collaborate with colleagues throughout the medical center to safely manage behavioral emergencies. We are all working together for the good of our patients and staff."</p>

helped to strengthen the impact of the team (see Table 1). Ongoing anecdotal comments continue to reinforce the value of the BERT.

The Behavioral Emergency Response Team Planning and Oversight Group continues to meet and discuss issues for continuous improvement. This oversight group was recognized with the institution's "Excellence Through Teamwork Award" for the project's positive impact on patient and staff safety. Replication of the BERT is occurring in other locations in this health system. Discussion during poster presentations at international, national, regional, and local venues has generated wonderful questions, ideas, and networking opportunities.

Challenges Encountered by the BERT

The largest challenge for the BERT was how to ensure psychiatric nurse and physician responders are available when there are requests for the team. The response role demands flexibility to reach the location of a behavioral emergent need within 10 minutes. Initially, the nurse responder was a psychiatric clinical nurse specialist during day shift on week-

days, and a psychiatric direct-care nurse the remainder of the time. At first, some of the psychiatric staff nurse responders were a little anxious about the situations they would encounter with the BERT. The challenges of available time, confidence, and consistency prompted exploration of alternative ways to cover the BERT. Psychiatric nursing team membership has now been focused on a small number of responders. Nursing confidence increased once nurses responded to a behavioral emergent situation and realized they were able to offer valuable assessments and intervention recommendations.

Conclusion

The BERT described in this article is a resource to meet the growing need for management of behavioral emergencies and the increasing rate of reported violence by patients. This BERT utilizes multidisciplinary mental health experts and security officers as responders. Identified calling criteria, data collection forms and review, and an oversight group maximize benefits from the resource. The team has been recognized as not only improving safety for patients and staff, but also enhancing staff satisfaction. Even though

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Objectives

This continuing nursing educational (CNE) activity is designed for nurses and other health care professionals who care for and educate patients and their families regarding behavioral emergency situations. For those wishing to obtain CNE credit, an evaluation follows. After studying the information presented in this article, the nurse will be able to:

1. Discuss workplace violence in the health care setting.
2. Describe the development of a behavioral emergency response team (BERT).
3. List the strengths and challenges of the BERT.

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the number of inpatient hospital units being covered expanded considerably, the number of calls did not increase correspondingly. There is no specific cause and effect relationship, but it is believed outcomes from the BERT responses are improving overall management of behavioral emergency situations at the medical center. **MSN**

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