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

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Background

UMMC • Located in the west side, metropolitan Baltimore area
• Brief overview- Fiscal Year 2015 statistics
  Licensed beds: 770
  Employees: 8,200
  Attending physicians: 1,200
  Resident physicians: 900
  Admissions: 30,500
  Emergency visits: 73,300
  Outpatient visits: 333,000
  Surgical cases: 22,100
  Maryland Express Care: 10,400

Unique clinical and community challenges in an urban, academic medical center
• Baltimore City is in the top 10 cities, reported by the FBI (2015), with the highest crime rates per 100,000 residents
• Baltimore also has the highest rate of heroin addiction in the United States (U.S.) with one in ten individuals affected, according to the U.S. Drug Enforcement Agency (2014)

Workplace Violence • 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
  • In 2011, the American Nurses Association (ANA) reported that acute and chronic stress, and feeling overworked were the primary concerns for 74% of nurses.

UMMC Workplace Violence Prevention: BERT antecedents
• 2011 Formation of interdepartmental/multidisciplinary teams: Patient/Public Conflict
• 2011 to present- Security assessment; increased instillation of cameras; staff training-
  gang violence, physical management of aggression techniques, self defense techniques; increased panic buttons; align mission of employees at entrances; revision of Workplace Violence policy
• 2012 Based on Senior Executive workplace environmental assessment, design group established to review best practices, explore and analyze operational feasibility, and launch a pilot for a workplace violence prevention performance improvement project

Methodology

1) Defining BERT at UMMC
A team consisting of a psychiatric nurse, a pastoral care staff, and a security officer providing immediate response, with 24/7 availability to a patient or visitor displaying disruptive behaviors that are not life-threatening

2) 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

3) Development of Behavioral Triggers Initiating BERT Response, Operational Algorithm,
• Staff perception of endangered safety and need for assistance
• Angry gestures, attempting to slap, kick or bite*
• Destruction of property or tampering with medical apparatus
• Verbal threats of suicide/self-harm
• Failure to accept medical/nursing recommendations with verbalized intent to harm others or self; deliberately undertaking treatment
• Patients who exhibit self destructive or self harming behaviors

4) BERT Interventions Identified and Refined
• Immediate assessment for safety
• Develop report 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 (Psychiatric Consultation & Liaison, Social Work, Patient Advocate, Risk Management, Employee Assistance Program)
• Recommend behavioral management plan
• Post event huddle
• Documentation in the patient’s medical record

Results

90 Day pilot with two units initiated 7/1/13, expanded to 22 units in 18 months, and total facility sequential rollout by 7/7/15

BERT Data FY 2014 & FY 2015
• Total calls = 209 (FY 14 = 95, FY 15 = 114)
• No injuries occurred
• Reasons for call-top 3
  - Patient agitation and threatening to staff
  - Family member being upset
  - AMA (Against Medical Advice) requests
• Average intervention time 30 minutes

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

Response Themes identified:
• Refusal of care and/or leave AMA
• Patient’s perceptions of not being listened to or not being respected
• Multidisciplinary team needs, everyone knowing plans/roles/expectations
• Patient & visitor disruption

Results (Con’t)

Security Data

Number of Security calls for Combative Patients

47% decrease from FY12 to FY14; 6% decrease from FY13 to FY14
32% projected decrease FY14 to FY15 based on Q1 to Q3
Q4 FY15 is 84% of entire FY14 - analysis ongoing

Implications for Practice/Next Steps

• BERT is a safe, effective program for de-escalation and prevention of violence in clinical settings, and is associated with increased staff competencies
• Further planning and enhancements include:
  • Addition of Complementary Medicine techniques for staff support and stress management (Aromatherapy and Breathing)
  • Compare rates of staff injury/days worked
  • Review Employee Opinion Survey results
  • Continue to address root cause issues contributing to patient agitation systemically
  • System analysis of FY15 Security calls for Combative Patient data

References


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