

Organization: University of Maryland Medical Center

Solution Title: Behavioral Emergency Response Team

Program/Project Description, including Goals:

Workplace violence is real and is 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. Being in an urban academic center in Baltimore City, we are vulnerable to potentially violent situations within the hospital. According to the FBI, Baltimore City is in the top 10 cities with highest crime rates per 100,000 residents. In 2011, our Senior Executive team conducted a security assessment. As a result of that assessment, we formed two teams: Patient/Public Conflict Team and the Co-Worker Civility Team. The goal of the Patient/Public Conflict Team was to develop strategies to prevent inappropriate behavior or confrontation within a patient/family and care provider situation or in situations that could potentially involve criminal intent.

Process: The process utilized was most closely linked to the Haden Matrix and utilizing the OSHA prevention guidelines.

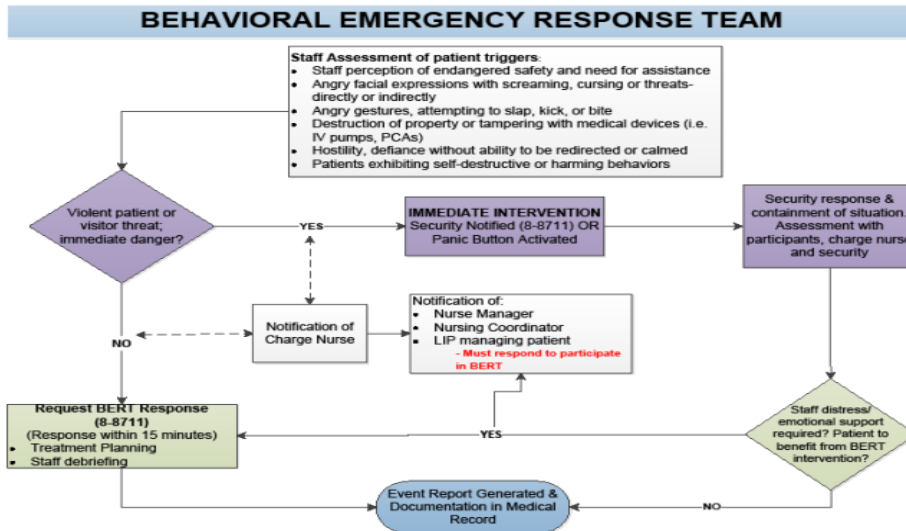
Solution: We created the Behavioral Emergency Response Team (BERT).

The goals of BERT are to:

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

The team is comprised of three core members: Psychiatric Emergency Services, RN, Pastoral Care and the Security Supervisor. An algorithm was developed outlining the triggers for

utilizing the BERT. (Figure 1)



The behavioral triggers for initiation of BERT are as follows:

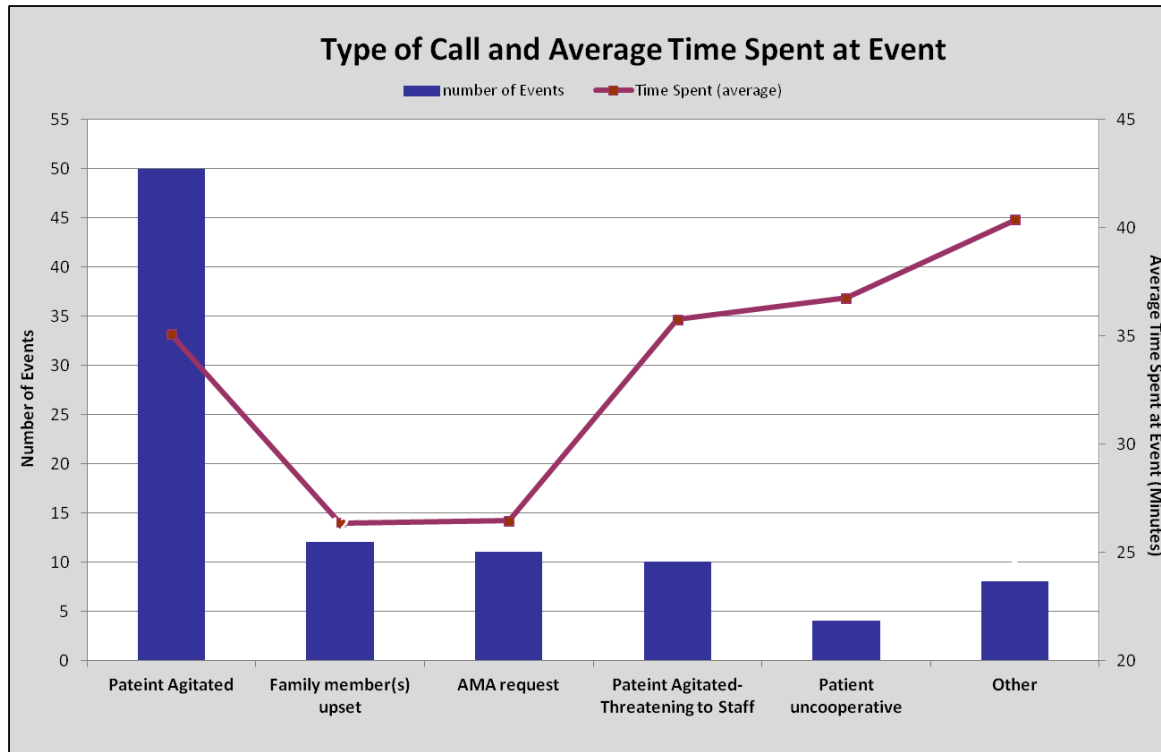
- Staff perception of endangered safety and need for assistance
- Angry facial expressions with screaming, cursing, words that threaten staff or others, indirectly or directly*
- Angry gestures attempting to slap, kick or bite*
- Destruction of property of tampering with medical apparatus
- Belligerence – 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)

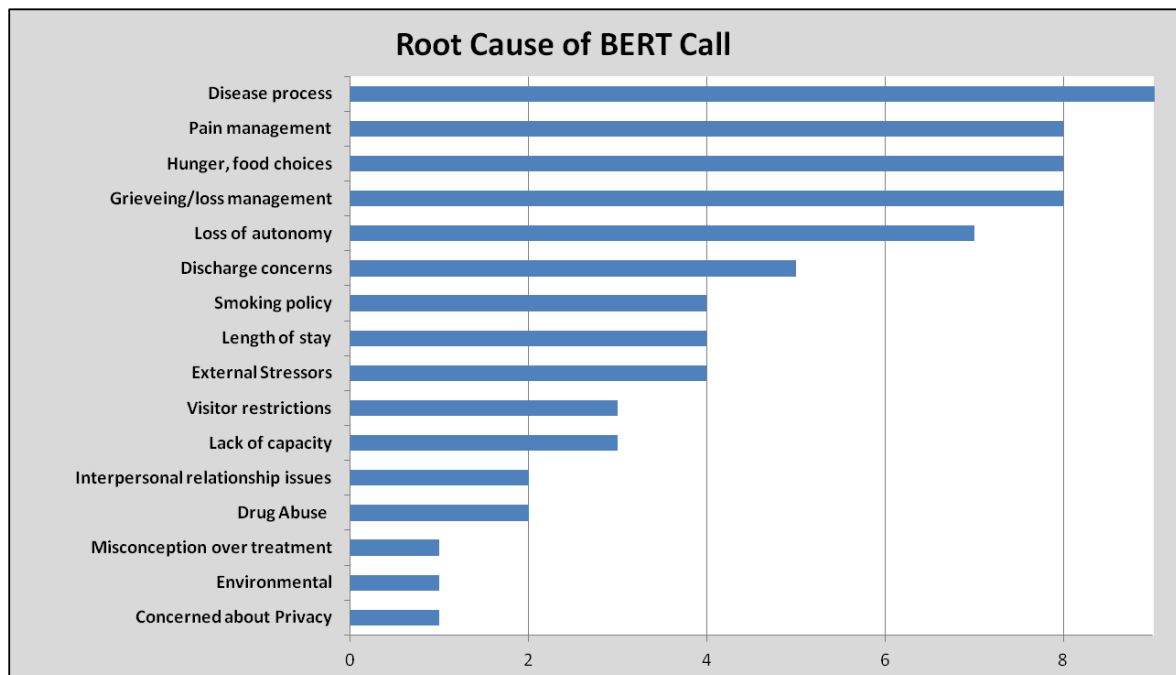
Measurable Outcomes:

- Total number of security calls for disruptive/combatative patients
- Total number of security calls for panic alarms
- Employee Satisfaction (this is a future measurable outcome...waiting for next EOS survey...we have our baseline data)
- Patient Satisfaction (again...have baseline data)
- Other measurable outcomes that we have identified for the future are: reduction in AMA's, reduction in workplace injury, improved reporting of workplace violence situations

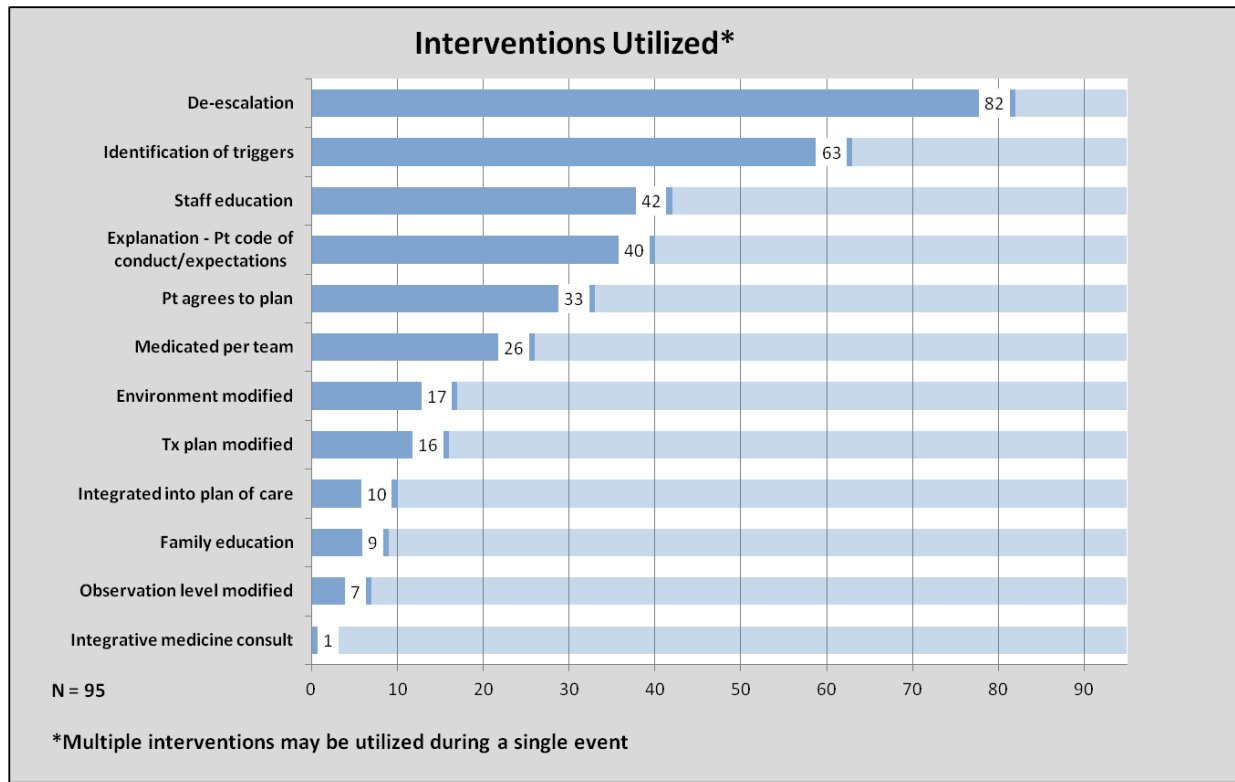
Characteristics of BERT Calls



Reasons for BERT Requests



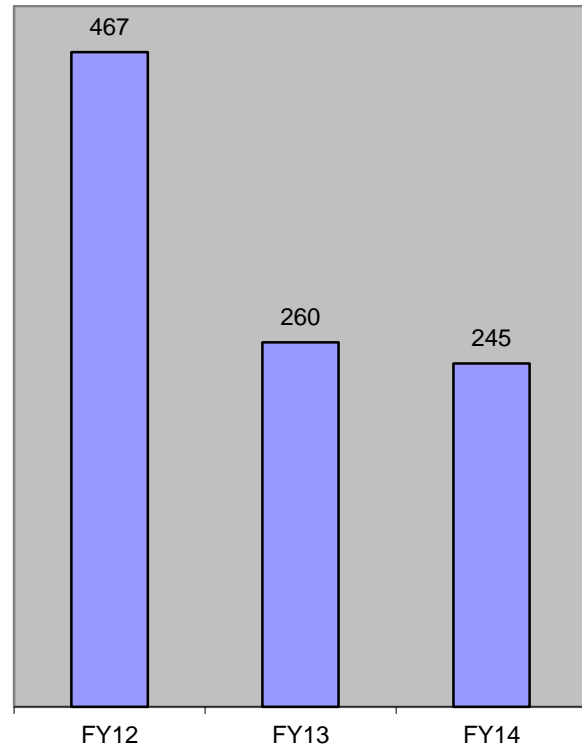
Actions of the BERT team



Security Data

Total number of calls to Security for Combative Patients

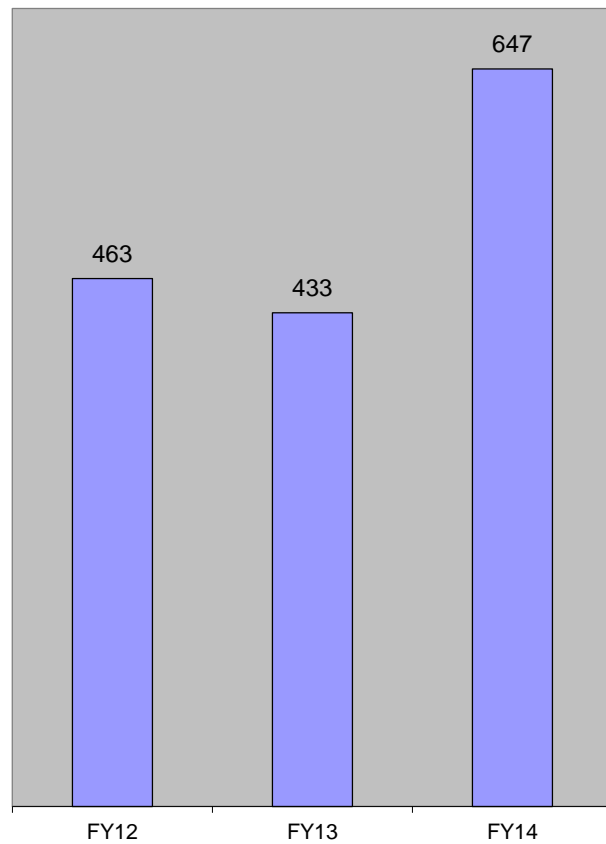
- 47% decrease from FY12 to FY14
- 6% decrease from FY 13 to FY14



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



Sustainability: This project began as a 90 day pilot program on 7/1/13. It was piloted on 2 nursing units: Medical Intensive Care Unit and the Shock Trauma Acute Unit. It has since rolled out to 20 acute units and will progress throughout the hospital.

Role of Collaboration and Leadership: From the inception of this program, it was endorsed by the senior executives: CEO, CNO, SVP Facilities/Operations, VP Nursing/Operations Shock Trauma Center and the Medical Directors. The membership of the Patient/Public Conflict Team is as follows:

Karen Doyle, VP Nursing/Operations Shock Trauma Center – Co-Chair
Maurice Davis, Director Security – Co-Chair
Thomas Scalea, MD – Physician-in-Chief Shock Trauma Center
Michael Winters, MD – Medical Director Adult Emergency Department
Chuck Schevitz, Human Resources
Susan Roy, Pastoral Care
Kim Nash, Cultural Diversity
Diane Gregg, Social Work
Erin Ruark, RN Emergency Department
Nicole Bailey, Guest Services
Victor Tabron, Perioperative Services
Deborah Stein, MD Chief of Trauma/Critical Care
Jennifer Beeker, Patient Access Services
Mary Gardner, Evelyn Jordan Center, Ambulatory
Leslie Evans, RN, Oncology
Erika Maynor, Radiation Oncology
Jim Chang, Director Safety
June Guadalupe, RN Trauma Resuscitation Unit
Connie Noll, RN Psychiatric Emergency Services
Minette Vergara, RN Medical Intensive Care Unit
Donna Parker, MD Student Affairs, University of Maryland School of Medicine
Antonio Williams, Chief of Police UMB
Jane Lipscomb, RN University of Maryland School of Nursing
Kate McPhau, RN University of Maryland School of Nursing

From the Patient/Public Conflict team, came the formation of the sub-committee to formulate BERT:

Connie Noll, MA, BSN, RN-BC – Lead Project Coordinator

Karen Doyle, MBA, MS, RN, NEA-BC – Executive Sponsor

Mark Bauman, RN MS CCRN
Senior Clinical Nurse II

Maurice Davis, MS, Lt. Col Retired
Director of Security, Guest Services & Transportation

David Glovinsky, MD
Division of Consultation-Liaison Psychiatry
University of Maryland School of Medicine

Theresa Kallman, MA, BSN, RN, CPHRM
Sr. Risk Manager
Maryland Medicine Comprehensive Insurance Program

Kerry Mueller, MBA, BSN, RN, CCRN
Nurse Manager MICU

Rev. Dr. Susan Carole Roy, D.Min., BCC
Director
Pastoral Care Services

Innovation: The BERT team is only the 2nd or 3rd of its kind in the country, as currently referenced in the literature. The team conducted a site visit at the University of Michigan, which has a comprehensive program to address disruptive individuals in their clinical setting. BERT is a unique and innovative way to manage the disruptive patient/family in areas outside the traditional psychiatric units. In addition, through this process, we are able to provide parallel education and modeling to our staff on de-escalation techniques and strategies.

Related Tools and Resources

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