

Behavioral Health Rapid Responses Teams (BHRRTs)

A summary of Best Practices

OVERALL GOAL OF BHRRTS

To support the need to care for a growing population of patients with medical/surgical, psychiatric, and behavioral complexity within an increase in incidents of patient to staff violence in hospitals

BHRRTs are an interdisciplinary team of healthcare professionals that provide a coordinated response for difficult and complex patients with disruptive behaviors.

BHRRTs respond to urgent requests from direct staff for support and to proactively identify patients who would benefit from psychiatric intervention to facilitate patient-centered care.

They can conduct an assessment of the situation, select and customize interventions, develop a care plan and assist with implementing interventions and post incident debriefing.

BHRRTs work with staff in emergency departments, behavioral health units, in-patient care units and even in surgical units to address behavioral disturbances on surgical recovery.

They promote patient and staff safety through early intervention using least restrictive measures possible and reduce the need for restraints and seclusions

They provide a role model for staff on the use of effective communication strategies for de-escalation

TEAM MEMBERS

Team leader-psychiatric RN or trained RNs on the medical/surgical or emergency units who were designated RRT leaders during certain shifts (if no psych RN on staff)

Team Members at a minimum

- RN
- Security staff
- A provider or Pharmacist (available by page or alerted when the RRT is activated for immediate review of patient medications for adverse reactions)
- In some facilities Pastoral care is included in the core team

Other Team Members may include:

- Psychiatrists
- The patient's primary provider
- Social worker or psychiatric social worker
- Psychiatric clinical coordinator
- Nurse aides
- Hospital police officers
- Risk management
- Staff, human resources staff
- Administrative staff
- Nursing leadership

ACTIVATION CRITERIA

Behavioral/Psychiatric Activation Criteria

- Staff perception of endangered safety and need for assistance
- Staff members are concerned with, worried about, overwhelmed with, or threatened by patient's behavior/Disruptive behavior upsetting unit function
- Sexual threats/issues/assaults and/or any other unwanted physical contact (spitting, intentional exposure by patient to bodily fluids)
- Acutely agitated patients (i.e., yelling, threatening, demanding, cursing) words that threaten staff or others, indirectly or directly
- Angry gestures attempting to slap, kick or bite
- Threats or perceived threats against self, others, or property
- Failure to respond to redirection or verbal de-escalation attempts
- Failure to accept medical/nursing recommendations with verbalized intent to harm others or self, deliberately undermining treatment
- Patient behavior representing imminent or actual danger to themselves or others/exhibit self-destructive or self-harming behaviors
- Patient responding to visual and/or auditory hallucinations or other impairment of reality impeding staff's ability to redirect or effectively communicate with patient

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Biomedical/Pharmacological Activation Criteria

- Patient in distress with deteriorating condition
- Patients who are unable to maintain control of their behavior in the clinical environment (confusion, delirium, chemical impairment)
- Drug or alcohol withdrawal leading to withdrawal symptoms or acting out behavior

Other Activation Criteria

- Concerns about behaviors related to placement of a 72 hour (involuntary) hold
- Threatening to leave hospital against medical advice
- Elevated scores on a violence risk assessment tool that include individuals who have a recent history of violence and aggression, and/or have exhibited anxiety (pacing, staring, irritability)
- Parents of minor patients with the above behaviors need special consideration

ACTIVATION METHODS

- Team-specific pager
- Routing activation calls through a central behavioral health services department who notifies the team members
- Alerting the behavioral health unit charge RN
- Specific phone number for team
- Using a violence risk assessment tool embedded in the nursing workflow
- A programmed report generated from the electronic medical record (EMR) based on nursing documentation that indicates behavioral need, for example, combative and restraints

TEAM INTERVENTIONS

- Customized interventions designed to de-escalate the behavioral crisis, starting with the least restrictive and most patient centered interventions.

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- Immediate interventions included verbal communication, calming techniques, and environmental/milieu changes
- Recommendations for medication administration, medication changes if the event was precipitated by medication reactions or interactions, or individual assignment for the patient
- Physical management (i.e., physical hold, violent or nonviolent restraints, seclusion) or transfer to a psychiatric behavioral health unit.
- Serial assessments to identify challenging patient behaviors, causes or triggers, and patterns.
- Initiation of standardized behavioral care plans are initiated that are reviewed with the patient's care team.
- Participation in the direct care of patients as an explicit method of role modeling use of behavioral techniques for staff

POST INCIDENT DEBRIEFING

Offer debriefing, education or a follow-up call for the patient's primary staff members who may have been less experienced with behavioral de-escalation

TEAM TRAINING AND IMPLEMENTATION PREPARATION

Delivery of training and content is variable depending the experience of the staff in managing behavioral de-escalation. Training for non-psychiatric staff is more extensive.

Extensive classroom-based training, online courses with in-person training, simulation scenarios, unit in-services, and inter-professional mock codes.

Some or all of the training was also incorporated into preexisting annual staff educational programming times to make attendance less burdensome to clinicians.

MEASURING OUTCOMES

<i>Process measures</i>	<i>Outcomes</i>
<ul style="list-style-type: none"> ▪ Number of BHRRT calls and usages ▪ Response length of time ▪ Reason for call ▪ Interventions used ▪ Shift/location ▪ Caller satisfaction ▪ Staff ability to manage patients with challenging behaviors on the inpatient medical and surgical units (via survey) ▪ Patient satisfaction 	<p>Indication that there is reduced:</p> <ul style="list-style-type: none"> ▪ Utilization of security services ▪ Restraint/seclusion use ▪ Reduced staffing requirements (1:1) ▪ Reduced staff injuries

Small to moderate improvements are indicated around staff knowledge, attitudes, and self-efficacy related to managing psychiatric patients and behavioral de-escalation and perception by staff of enhanced safety at work.

There is some indication that role modeling behavioral de-escalation, debriefing, and education for non-RRT staff was a critical component of intervention success and eventually reduced need for the psychiatric RRT altogether as staff improved their own behavioral de-escalation skills.

In one hospital, tracking and communicating process outcomes for BHRRT raised leadership awareness of the growing burden on staff to manage violent situations for which they were not trained

CHALLENGES AND BENEFITS

Implementation of BHRRTs

The Iowa Model of Evidence-Based Practice for Implementation to frame the BHRRT implementation process in some hospitals with good success. Piloting the BHRRT on some units before house-wide implementation appears to support successful implementation house-wide.

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Sustainability challenges:

How to ensure:

- The availability of psychiatric RRT responders (particularly for hospitals without inpatient psychiatric staff)
- Consistent training for team members and general staff awareness of RRT resources with staff attrition and turnover
- Excessive resource drain
- Gaining staff and leadership buy-in,
- Staff waiting too long for all the psychiatric RRT or continuing to call security 1st.

Modeling implementation of a sustainable BH RRT could be based on existing research around implementation of medical RRTs in the acute care setting. Overall information about medical Rapid Response Teams can be found at www.IHI.org

The information above was summarized from the following resources:

An Integrative Literature Review of Psychiatric Rapid Response Teams and Their Implementation for De-escalating Behavioral Crises in Nonpsychiatric Hospital Settings (2019). Choi, K. R., Omery, A. K., & Watkins, A. M. The Journal of Nursing Administration, 49(6), 297-302.

An interdisciplinary clinical approach for workplace violence prevention and injury reduction in the general hospital setting: SAFE response (2018). Lakatos, B. E., Mitchell, M. T., Askari, R., Etheredge, M. L., Hopcia, K., DeLisle, L., & Higgins, M. Journal of the American Psychiatric Nurses Association, 25(4):280-288.

Behavioral emergency response team: implementation improves patient safety, staff safety, and staff collaboration (2017). Zicko, C. J. M., Schroeder, L. R. A., Byers, C. W. S., Taylor, L. A. M., & Spence, C. D. L. Worldviews on Evidence-Based Nursing, 14(5), 377-384.

Behavioral Rapid Response Team (2017). PowerPoint. Gallagher, M., et al. Southern New Hampshire Health
http://www.ahaphysicianforum.org/webinar/2017/files/Southern_New_Hampshire_Slides.pdf

Behavioral Emergency Response Team (2014). University of Maryland Medical Center

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http://www.marylandpatientsafety.org/documents/Annual_Conference_2015/Solutions/Behavioral_Emergency_Response_Team.pdf

Crisis prevention team calms agitated patients in psychiatric units, leading to a reduction in the use of restraints and seclusion and fewer injuries (2008). AHRQ Health Care Innovations Exchange. Ferguson, J. & Leno-Gordon, D. <https://innovations.ahrq.gov/profiles/crisis-prevention-team-calms-agitated-patients-psychiatric-units-leading-reduction-use>

Memorial Hermann Health System – Psych Response Team. America Hospital Association Case Study

<https://www.aha.org/case-studies/2017-06-22-memorial-hermann-health-system-psych-response-team>

Proactive psychiatry intervention using a nurse-led behavioral response model for hospitalized patients with behavioral disturbances. (2019). Afriyie-Boateng, M., Loftus, C., Wiesenfeld, L., Hunter, M., & Lawson, A. The Journal for Healthcare Quality 41(5), 267-273.

Rapid response team in a psychiatric hospital (2017). Jessica O. Hay et al. American nurse today 12(8), 47-48.

<https://www.myamericannurse.com/rapid-response-team-psychiatric-hospital/>