

Practice Implications for Clinical Nurse Specialists' in a Behavioral Emergency Response Team

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Froedtert Hospital

- Beds
 - 585 Beds
- FY17 Admissions
 - 29,386
- Emergency Visits
 - 71,989
- Births
 - 2,701



Background

- Increasing volume and acuity of psychiatric patients
- Staff accidents related to patient violence on the rise
- Lack of dedicated inpatient space for psychiatric population
- Knowledge gap in the areas of de-escalation and behavioral management

Background

- A multi-disciplinary group was developed at the direction of our Chief Nursing Officer and Chief Medical Officer to establish a team that could respond to behavioral emergencies 24/7
- Expected outcomes of the group:
 - Provide support to frontline clinical nurses
 - Facilitate a safe and secure environment for patients/visitors/staff
 - Develop a pathway that provides proactive stabilization of psychological symptoms of distress
 - Engage the appropriate care team members to modify or continue the patient's plan of care

Starting Point

- Must utilize current available resources to make this budget neutral
- Lack of specialized psychiatric nurses
 - No inpatient psychiatric unit
- Short time period for implementation

Plan

- Model behavioral emergency response team (BERT) after current rapid response team (RRT) structure
- Utilize resources already available within security and RRT
- Engage help from the developing charge nurse group and supplement with administrative supervisor presence

Plan

- Provide clinical oversight with Clinical Nurse Specialist group
- Provide comprehensive de-escalation and psychiatric training to all team members
- Implementation on Inpatient areas, excluding ED and ambulatory

Team Composition

- First Responders
 - Security officers
 - Rapid response nurse
 - Charge Nurse (day shift)/Administrative Supervisor
- Secondary Responders (activated only as needed by the CNS)
 - Social work/case management
 - Chaplain/Spiritual services
 - Psychiatry
 - Pharmacy

Code Orange Process

Patient becomes aggressive, threatening, or otherwise disturbing to people around them



Code orange activated by anyone in the hospital using Vocera or phone ext.



Security dispatcher asks if the person causing the disturbance is an inpatient



If yes, BERT is paged along with code orange response

If no, only security is dispatched to de-escalate the situation

Rapid Response Nurse

- Role:
 - Team leader
 - Provide immediate help to the frontline nurse who is caring for a patient experiencing distressing, agitated behaviors
 - Assess patient's medical stability
 - Utilize agitation algorithm to stabilize the patient's behavior

Agitation Algorithm: <I:\FMLH\Advance Practice\BERT\Agitation Algorithm 5.3.17.pdf>

Agitation Algorithm

The Code Orange (BERT) First Responder RNs will refer to the Agitation algorithm during a response. This algorithm guides the team to:

- Manage the acute episode in a coordinated approach
- Assess the environment for contributing factors
- Assess for medical stability
- Assess for the most probable etiology of behavioral symptoms
- Recommend or implement interventions to stabilize the situation
- Identify recommended medications and dosing to discuss with the provider

Security

- Role:
 - Assess the environment for safety
 - Help to diffuse and de-escalate the situation
 - Provide physical intervention when needed (i.e. locked restraint placement)

Training Plan

- **De-escalation training course**
 - 8-hr workshop taught by organizational learning department
- **Two-hour BERT training class**
 - Taught by Psychiatry
 - Topics of Delirium, Substance use, Psych disorders
- **Verbal Judo**
 - Verbal de-escalation course taught by retired law enforcement
- **Simulation**
 - Code Orange scenario facilitated in simulation center by nurse educator, CNS, and organizational learning

CNS- Post Acute Event

- Complete a comprehensive and holistic assessment of the patient's clinical situation as needed within a reasonable timeframe after the event
- Identify potential risks to the patient, family or staff
- Perform a medication review
- Collaborate with others to design strategies/interventions to meet the needs of complex patients
- Facilitate intraprofessional team member communication as needed

CNS- Post Acute Event

- Goal:
 - Decrease the number of acute episodes and prevent repeat calls
- Documentation:
 - Smart text created within EHR
 - Follow-up to occur within 24-48 hrs
- CNS determines need for further follow-up

CNS Follow up Note

Female, 54 Y, 07/18/1963 Location: 4SW FH MRN: 10008028 Attend Prov: STET... Code: Not on file Inf: None Interp: No MyChart: Ina...
E MRN: 304000011 WT: 52.2 kg (...)

Notes

Apple, Molly - New Note by ANJOU, SIDNEY

Type: Progress Notes Service: Date of Service: 7/19/2017 03:28 PM

Cosign Required

Clinical Nurse Specialist Code Orange Follow-Up

Code Orange Event Date and Time: ***

Code Orange Summary & Assessment: ***

Etiology of Behavior: {Code Orange Etiology of Behavior:25674}

Most Recent Nursing Delirium Screening Scale (NuDesc) or Confusion Assessment Method for the ICU (CAM-ICU) Score: ***

Pharmacological Interventions Given: {Code Orange Pharmacological Interventions:25675}

Non-pharmacological Interventions: {Code Orange Non-pharmacological Interventions:25676}

Patient Response to Interventions: {Code Orange Patient Response:25677}

Identified Behavioral Triggers/Patterns: ***

Medication Review/Scheduled Medications: ***

Current treatment plan: {Code Orange Current Treatment Plan:25678}

Continued Clinical Findings: {Code Orange Cont Clinical Findings:25678}

Future plan/recommendations: ***

Barriers to plan of discharge: ***

Education/Resources provided: ***

Pend Sign Cancel

Customize

Advice to the Non-psych CNS

CNS BERT “Toolbox”

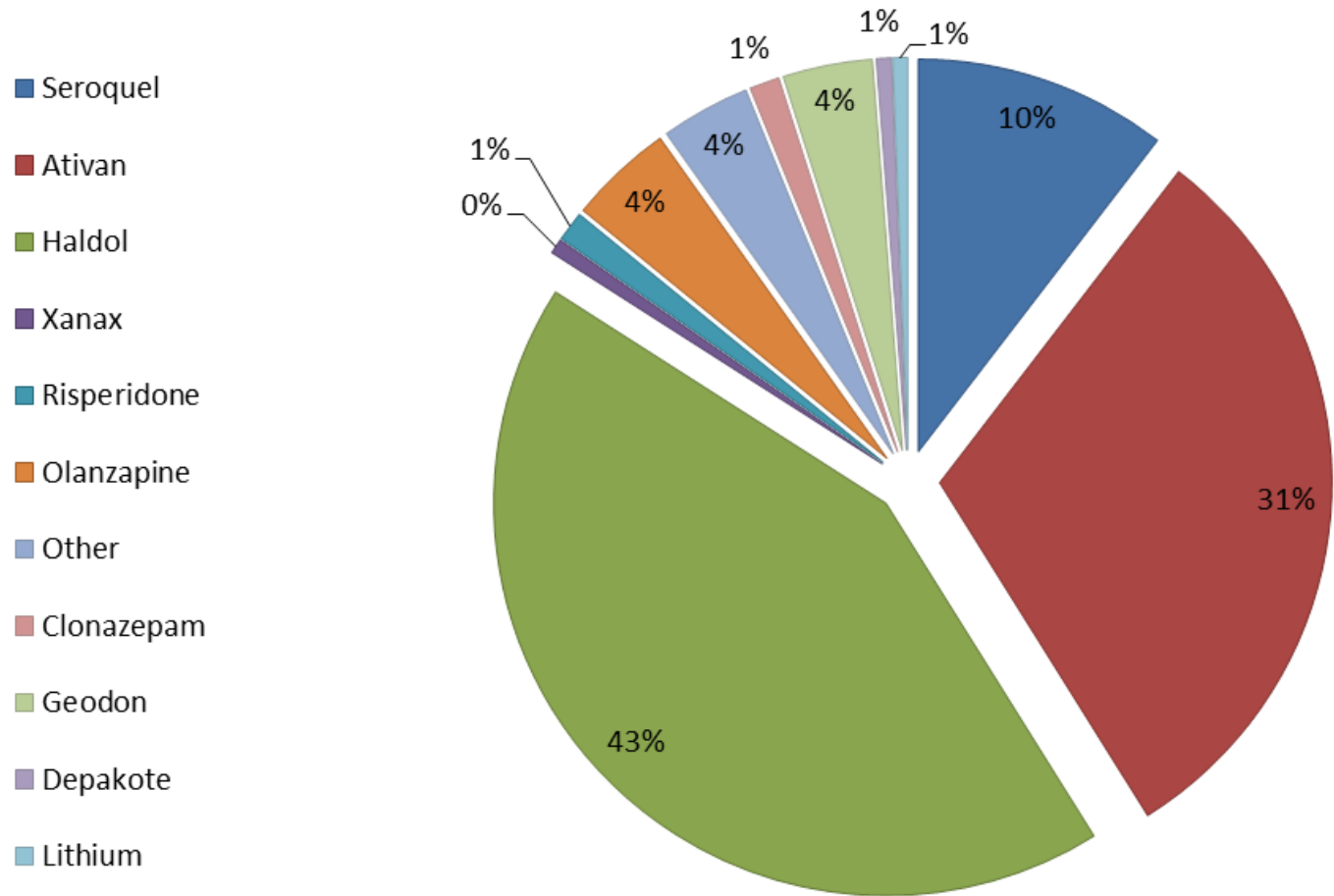
- ❑ Check Delirium report in Epic for deliriogenic medications
- ❑ Follow-up with social work- is the patient still on track for their discharge plan? (do we need to d/c sitter prior discharge, do we need to d/c teleobservation prior to discharge? What do we need to do in order to accomplish these items? etc.)
- ❑ Follow-up with the patient and/or family if available: do they have any questions or concerns
- ❑ Follow-up with the RN: are there any on-going concerns, how did the patient respond to interventions, is the patient still exhibiting behaviors that might require Code Orange/BERT/Sheriff
- ❑ Review notes from psych and medicine teams, is the recommended plan of care being implemented?
- ❑ If there are any process concerns, contact the administrative supervisors. They will be in charge of completing a “just in time” post-event survey that captures process improvements, resources, etc.

Outcomes

(5/17/17-1/31/18)

Total # of calls	517
Median length of BERT call	25 mins
Total# of repeat calls	39.6% (184)
% of patients placed in restraints at time of call	22%
Pysch seeing patient at time of call	36%
New Psych consults obtained as result of BERT	8.30%
Geriatrics seeing patient at time of call	4.40%
Pharmacological intervention used during call	36%
Average time range to complete CNS f/u	31-45 mins

Medication Administration Frequency



Case Example 1

- 33 y/o female with CP/MR, trach and vent dependent at night. Presents to ED as mom unable to care for her at home any longer. Pt had removed herself from vent numerous times.
- Numerous Code Oranges called for behaviors. Throwing things, swearing, hitting.
- Long inpatient stay due to placement issues. Denied from all facilities due to behaviors

CNS follow up

- Psych involved
- CNS behavior plan including
 - Earn stickers for good behavior, every 5 stickers she can chose an activity to do for 30-60 minutes
 - Create list of behaviors that earn stickers
 - Rotate special activities every 3-4 days

CNS follow up

- Behavior plan continued
 - Do not reward with food, limit desserts (ADLs, sugar levels)
 - Negative behaviors should lead to loss of attention
 - Remove items from reach, leave her alone, time outs
 - Paper/plastic utensils, keep nails short

CNS follow up

- Behavior plan continued
 - Exercise for 10 minutes in am and pm
 - Should not be allowed to pick her caregivers
 - Earn stickers for being kind and accepting of a new caregiver
 - Long term rotating caregivers

Case Example 2

- 31 y/o female presenting with headaches. PMH includes cirrhosis and etoh abuse. Very remote history of psychosis.
- Found to have fungal meningitis.
- Admitted to medicine with Infectious Disease consulting.
- Patient did well for a few days then started having hallucinations and agitation. Two Code Oranges called. Patient in hallway yelling, jumping over carts. Restraints used periodically.

CNS Follow up

- Review of chart and past medical history
- Review of labs, vitals, and medications.
- Psych consult order had been placed.
- 1:1 sitter, restraints removed
- Patient is on a few deliriogenic medications
- Will be having some procedures

CNS Follow up

- Spoke with the medical team and nursing staff
- Discussed delirium treatment interventions
- Watched patient the next few days
- Discussed with team the impact of her liver failure and her plan of care
- Patient continues to decline but no further threats to safety of patient or staff
- No further Code Oranges since CNS involvement in coordination of care

Future State

- Addition of Pittsburg Agitation Scale to the BERT process as another way to measure effectiveness of interventions during call



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