Weill Cornell Medicine

C-L 911! Pilot Implementation of a Behavioral Emergency Response Team Reduces Work-Related Injuries from Patient-to-Staff Violence

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Background: A behavioral emergency response team (BERT) is an interdisciplinary rapid response team for behavioral emergencies on non-behavioral health units. National trends in implementation and literature findings exist mostly in the domain of behavioral health nursing (Loucks, 2010). To our knowledge, there is no current publication describing an interdisciplinary BERT implementation on a psychiatry consult-liaison (C-L) service.

Methods: Our C-L psychiatry department implemented a BERT pilot across all non-psychiatric inpatient floors as part of a quality improvement initiative. In addition to the primary team physician and nurse, our BERT teams consisted of a member of the C-L service (psychiatric resident or nurse practitioner), security, and nurse manager. We reviewed electronic health record data from the first 5 months post-implementation, specifically focusing on precipitating etiologies/events, interventions, and outcomes. We compared reports of work-related injuries from patient-to-staff violence over the 5 months pre- and post-intervention.

	BERT Patients (n=49)	Inpatients (n= 13,878)
Average Age ± SD (years)	56.1 ± 22.4	59 ± 22.0
Average LOS ± SD (days)	18 ± 18.2	7 ± 11
% Male	59.2%	50.1%
Disposition		
% Psych Hospital	14%	2.1%
% Rehab Facility	16.3%	1.8%
% AMA	10.2%	1.5%
% Home	40.8%	77.1%

Table 1. Demographic features of patients with BERT activations.

Results: There were 63 BERT activations representing 49 patients. Physical agitation was the precipitating event in 45% of activations, verbal agitation in 29%, self-injury in 6.5%, and destruction of property in 4.8%. 15% occurred after an assault to staff. The most common precipitating event was behavioral manifestations of confusion/delirium (41.9%), followed by patient perception of not being listened to or request being denied (29.0%), and attempt to leave against medical advice or elopement (9.7%). The most common underlying cause of the behavior was delirium (37%), followed by primary psychiatric illness (23%), interpersonal difficulties (13%), and substance withdrawal (6%).

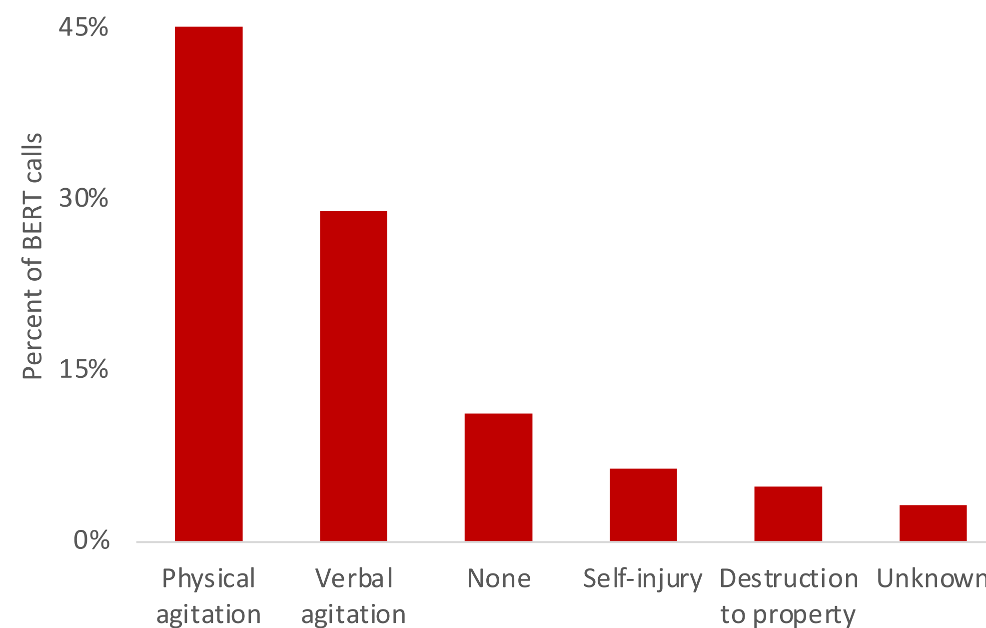

Fig 1. The BERT was most commonly activated for physical agitation.

Results (cont): Excluding BERT activations in which no acute intervention was needed, verbal de-escalation was utilized in 89% and psychotropic initiation/changes were recommended in 80%. The C-L service was already consulted in 48% of activations, and 47% resulted in placement of new consults. Reported work-related injuries from patient-to-staff violence decreased by 26.2% post-BERT launch.

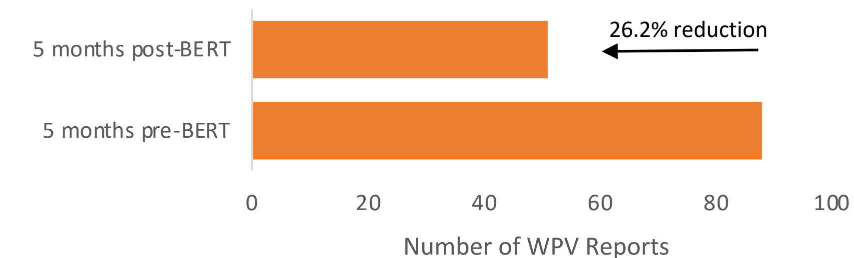

Fig 2. Reported patient to staff work-place violence (WPV), including both physical and verbal violence, decreased by 26.2% post-BERT launch.

Conclusion: The BERT was a feasible and effective means of rapid evaluation of patients in the general hospital setting exhibiting an acute behavioral emergency and was associated with a decrease in reported work-related patient-to-staff violence. BERTs play an emerging role for reducing harm in the medical setting. Given the expertise of C-L psychiatrists in management of agitation in the general medical setting, our discipline should be involved in further clinical work and research on BERTs.

References

1) Loucks, J., Rutledge, D.N., Hatch, B., Morrison, V. Rapid Response Team for Behavioral Emergencies. J. Am. Psychiatr. Nurses Assoc. 2010;16(2):93-100