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| Supplement 1: Evidence Table | | | | | | | | | |
| **Citation** | **Design/Sample/Setting, Evidence Level and Quality** | **Team description** | **Activation Criteria** | **Team Interventions** | **Team Members** | **Implementation** | **Measures** | **Outcomes** | **Lessons learned** |
| Pestka, E. L., Hatteberg, D. A., Larson, L. A., Zwygart, A. M., Cox, D. L., & Borgen Jr, E. E. (2012). Enhancing safety in behavioral emergency situations. *Medsurg nursing*, *21*(6), 335. | 6 general medical units  Large midwestern hospital  Level 5/A | BERT (behavioral emergency response team)  Led by RN; psychiatrist carries BERT pager and is available as needed. Security provides hand-on de-escalation assistance as needed.  Assessment, select interventions, develop care plan, team debriefing  Phone call to unit 4 hours after event to assess effectiveness of intervention  Education plan for medical units to understand how and when to utilize BERT | A staff member is worried about the patient’s behavior  Threats or perceived threats against self, another person, or property  Sexual threats/issues/assaults and/or any other unwanted physical contact (spitting, intentional exposure by patient to bodily fluids)  Concerns about behaviors related to placement of a 72-hour(involuntary) hold  Disruptive behavior upsetting unit function | Verbal communication  Calming techniques  Environmental changes  Medication  Recommending an individual assignment  Restraints (last resort) | Psychiatrist  Psychiatric Nurse  Security | Psych RNs assigned shifts to respond to BERT calls  Primary provider notified when BERT is activated  Psychiatrist makes recommendations for meds but primary provider orders.  Online and in-person training classes for RNs to understand BERT responsibilities; included simulation scenarios  Ongoing annual safety training for RNs.  Less intensive training for physicians/security | RRT form:  Caller  Date  Time of day  Location  Length of response  SBAR summary  Interventions used  Process needs  Learning needs  Satisfaction of caller  Other feedback | 39% of calls on days  39% of calls on evenings  21% of calls on nights  M response length: 43.5 minutes (range= 5-220)  Hyperactive delirium was the most common reason for calling, followed by alcohol/nicotine withdrawal, psychosis, suicidality, disruptive behavior, intention to leave AMA  Most common interventions: Verbal (75%), calming techniques (48%). Meds ordered in 53% of events.  99% of interventions were effective and remained effective 4 hours later. | Role modeling from BERT psych RN, psychiatrist, and security was valuable; learning from the BERT responses reduced reactive need for assistance over time  Led to greater awareness of assessing, diagnosing, and treating symptoms of acute delirium.  Increased focus on identifying patients with a history of alcohol abuse or dependence  Challenges: how to ensure psychiatric nurse and physician responders are available when there are requests for the team  Improved satisfaction, collaboration, and staff perception of safety |
| Jones, C. D., Manno, M. S., & Vogt, B. (2012). Tier one alert! A psychiatric rapid response team. *Nursing management*, *43*(11), 34-40. | 2 hospital campuses  Community hospital system in New Jersey  Level 5/A | Tier one alert  Emphasis on understanding one’s  own behaviors (both nurse and  patient), a patient’s active involve-  ment in problem solving, and  promoting the interpersonal pro-  cess (relationship)  Tier one alert responder (RN) acts as the team leader and communicates with the patient.  Security offers support and hands-on intervention if situation becomes violent.  Pharmacist evaluates patient’s medication profile to identify interactions or adverse reactions that might be contributing to the situation. | An individual’s  behavior represented imminent or actual danger to  themselves or others. | Verbal communication  Medication changes  Physical management if necessary | Tier one RN  Security  Nursing supervisor  Pharmacist  Primary RN | Designated tier one responder on a particular nursing shift by unit (RN) trained  8-hour training program for all team members; 4 hours of this were hands-on behavior management practice  Primary RN activates team | Number of code grey and tier one events | Reduced code grey events (39% reduction); overall reduced behavioral health events 21% reduction)  Increase in patients awaiting transfer to psychiatric units within medical units | Overall reduction in behaviorally disruptive events attributed tier one staff who utilized the skills learned through tier one alert training and found application to a variety of patients and non-tier one staff members who observed and participated in tier one interactions  Challenges: Inconsistent training; staff attrition/turnover resulting in new staff who had not received training |
| Kelley, E. C. (2014). Reducing violence in the emergency department: a rapid response team approach. *Journal of emergency nursing*, *40*(1), 60-64. | 1 240-bed community hospital in Massachusetts  Level 5/B | De-escalation Team/Code S  Primary RN leads de-escalation with team standing by when Code S is initiated. Goal is to initiate early, before behavior escalates.  If the primary caregiver escalates  during the situation, they are “tapped out” by the first  responder, who takes report and continues the communication  with the patient. | Staff members feeling overwhelmed or threatened when dealing  directly with an escalating individual  Individuals who are unable to  maintain control of their behavior in the clinical environment  (confusion, chemical impairment,  mental illness, difficult emotions) | Verbal de-escalation techniques  Seclusion or restraints as a last resort. | Physician  Nurse  Social worker  Technician  Security  Human resources  Administration  Risk management staff | Crisis prevention training for all ER staff, which teaches that caregivers are better able to  maintain a de-escalating demeanor, thus controlling the situation, when the patient  and the caregiver know that ample support is standing by. | Team utilization  Restraint and seclusion use  Staff injuries | 650 usages in ER  Before: 30% of behavioral health hours were spent in locked seclusion  After: 1% (restraint) and 2% (seclusion) of behavioral health hours  Reduction in take-downs and staff injuries (data not available) | Concerns: Excessive drain on ER resources |
| Loucks, J., Rutledge, D. N., Hatch, B., & Morrison, V. (2010). Rapid response team for behavioral emergencies. *Journal of the American Psychiatric Nurses Association*, *16*(2), 93-100. | 1 500-bed Magnet facility in Southern California; piloted on medical pulmonary unit and then implemented in full hospital  Level 5/A | Behavioral emergency response team (BERT)  Trained and experienced psychiatric nurses take de-escalation and milieu management skills to nonpsychiatric hospital units where patients with psychiatric conditions were exhibiting risky or scary behaviors  Staff on unit call Behavioral Health Services (BHS); BHS staff will alert house supervisor that BERT has been called.  After the incident, BERT team de-briefs with unit staff and provide teaching as needed. | -Acutely agitated patient [i.e., yelling, threatening, demanding, cursing, responding to hallucinations or delusions]  -Patient in distress with deteriorating condition  -Patient at risk for: danger to self, danger to someone else  -Patient who is confused and threatening to leave hospital Against Medical Advice.  -Patient experiencing drug/alcohol withdrawal signs or symptoms, and exhibiting acting out behavior. | BHS RN will assess patient condition and facilitate stabilization of patient behavior.  -BHS Clinical Coordinator/Charge Nurse will collaborate with assigned RN to modify or implement appropriate plan of care.  -BHS Clinical Coordinator/Charge Nurse will document briefly in progress notes regarding consultation call utilizing SBAR and will complete BHS BERT form. | BHS nurse with Management of Assaultive Behavior Designation to write 72 hour holds  BHS social worker  BHS clinical coordinator | Used Iowa Model of EBP for implementation  On-duty BHS staff comprise BERT team  Promote awareness of BERT among MDs through committees, Medical Staff Briefs, etc.; awareness of BERT among nurses promoted through staff meetings, unit newsletters, daily hospital newsletter, flyers, and Nurse Leadership Team, etc. | -Positive feedback from physicians and staff  -Monthly trending of numbers of patients treated and stabilized.  -Staff surveys regarding knowledge/attitudes  -Debriefings of BERT calls | 54% of nurses (N=39) have a good understanding of BERT  31% report their level of comfort with psychiatric patients is high  14% involved in a BERT call; 100% of those believed the patient’s needs were met | Role modeling of psychiatric interventions to nonpsychiatric personnel occurs, which may enhance skills in medical–surgical staff members and promote their confidence in addressing similar issues in the future |
| Wong, A. H., Wing, L., Weiss, B., & Gang, M. (2015). Coordinating a team response to behavioral emergencies in the emergency department: a simulation-enhanced interprofessional curriculum. *Western journal of emergency medicine*, *16*(6), 859. | 1 large public hospital in New York City  Level 5/B | Interprofessional education intervention for behavioral crises in the ED  Simulation-enhanced patient safety  curriculum targeting staff attitudes toward patient aggression  and interprofessional collaboration during the management  of patients with behavioral emergencies in the ED  Didactics: crisis management principles, de-escalation  techniques, roles & responsibilities, and proper application of restraints  Standardized patients and simulation with two case studies that both escalate to restraint application | NA | NA | ED staff:  Physicians Nurses  Patient care technicians  Hospital police officers | Engaging and securing administrative support  Trainings delivered during established training times for physicians and nurses  Nursing: incorporated into annual competency training | Management of Aggression and  Violence Attitude Scale (MAVAS) | Internal factors, external factors and situational/  interactional perspectives on patient aggression improved post-intervention  Staff attitudes toward management  of patient aggression did not significantly change  Staff participants overwhelmingly endorsed and  welcomed the SPs in the hands-on components of the  course and frequently commented on how having SPs in the  simulations significantly increased fidelity and helped recreate  a realistic scenario for them. | Challenges: Time and resource-intensive training  Core team of physician, nursing, and police educators was needed to ensure consistency in training  Requires a robust simulation center |
| Zicko, C. D. R., Schroeder, L. C. D. R., Byers, C. D. R., Taylor, L. T., & Spence, C. D. R. (2017). Behavioral emergency response team: implementation improves patient safety, staff safety, and staff collaboration. *Worldviews on Evidence‐Based Nursing*. | 1 military treatment hospital in Virginia; piloted on 1 unit and then expanded to 2 additional units  Level 5/A | Behavioral emergency response team (BERT)  Timely consultation  and intervention, including (a) deescalating individuals  who may exhibit potentially violent behaviors; (b) role modeling  crisis intervention skills, which may improve non-MH staff  members’ abilities and promote confidence addressing similar  behavioral issues in the future; (c) debriefing unit staff after  the situation is defused; and (d) providing education  MH charge RN serves as the team leader and consults with psychiatrist or primary provider as needed. Primary nursing staff administers medications or other interventions recommended by BERT RN.  The charge nurse for the patient’s  unit notifies all BERT members of activation; the MH  unit charge nurse is provided a description of the situation.  Group debriefing after incident; primary RN completes a follow-up assessment 4-6 hours after the incident. | - Patient responding to auditory and/or visual hallucinations or  other impairment of reality impeding staff’s ability to redirect  or effectively communicate with patient  -Concern the patient’s psychiatric condition is deteriorating and  that the patient and/or others may be in impending danger  -Agitated, disruptive, threatening, and/or acting out behavior is  not responsive to staff’s redirection or other attempted  Interventions  -Sexual threats, assault, or unwanted physical contact | Verbal deescalation Therapeutic calming  Techniques  Environmental interventions | Mental health RN  Psychiatric technician  Primary resident  Primary RN  Security (not often needed; security reported to the charge nurse, and within 10–15 minutes  the BERT leader or charge nurse made the decision if  security needed to stay for a show of support or if they could be  dismissed) | Implemented using Iowa Model of Evidence-Based Practice  Training provided by CNS  In-service for medical unit from a psychiatric MH nurse  practitioner reviewing signs of behavioral escalation  and early intervention and communication techniques  to keep the patient and staff safe | Staff knowledge, confidence, and support caring for psychiatric patients  Staff assaults and injuries  Restraint usage  Security intervention  Code greens | Assaults  and security intervention decreased by 83%  Restraint  use decreased by 80%  During expansion, the number of assaults,  security interventions, and restraints decreased by 90%, 93%,  and 87.5%, respectively  Staffs’ level of BERT knowledge and level of support between  MH and MS staff both significantly increased, although their  level of confidence in caring for psychiatric patients or patients  experiencing behavioral emergencies was rated as moderate | Security was often not needed, when the  BERT leader was able to quickly assess and determine if the  situation could be deescalated safely without security intervention.  Challenges: Gaining staff and leadership  buy-in, particularly on the MH unit (required MH staff to leave their unit); maintaining staff knowledge of the  BERT and buy-in when staff frequently turns over due to deployments,  duty station changes, and training exercises that  occur in the military setting; mirroring a medical RRT; staff wait too long to call BERT |
| Mackay, A. (2017). The Critical Role of the Psychiatric Emergency Response Team in the Adoption of a Violence Risk Assessment Tool (Doctoral dissertation, Walden University). | 1 458-bed level 1 trauma hospital in St. Paul, Minnesota  Level 5/A | Psychiatric Emergency Response Team (PERT)  MIAHTAPS (7 points of assessment) violence risk assessment tool completed by RN once per shift; encouraged to page PERT team if patient has potential for violence | MIAHTAPS score of 3 or higher | Medications  Verbal de-escalation  Restraints  Consulting psychiatry team  Transferring patient to psychiatric unit | Mental health nurse  Mental health associate Security | Violence risk assessment tool was built into the nurses’ current workflow  Direct care staff were trained using the  online education program about the MIAHTAPS assessment tool | Staff assaults  PERT calls  Restraint usage | Physical restraints  were reduced by 5%  75% of nurses used MIAHTAPS and 73% believed it was useful  Nurses still tended to call security first instead of requesting a PERT team | Recommendations: Addition of a Clinical Nurse Specialist or a psychiatrist to the team to have  consistency in medication orders as well as increase the time of getting medication  Orders  Ongoing training for direct care staff with the education on behaviors  to assess |