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Behavioral Code Team

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This Manuscript Partially Fulfills the Requirements for the

Doctor of Nursing Practice Program and is Approved by:

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April 09, 2022

University of St. Augustine for Health Sciences
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Behavioral Code Team

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Abstract

Practice Problem: The organization lacked an evidence-based intervention for behavioral emergencies within the inpatient acute care setting, leading to increased mechanical restraints. A security-driven paradigm was the organization's primary tool for addressing behavioral crises and lacked a more patient-centered treatment and support paradigm.

PICOT: The PICOT question that guided this project was In the Veteran patient population admitted to acute inpatient services (P), how does having a behavioral code team respond to behavioral emergencies (I) compared to the current practice (C) affect the prevalence of mechanical restraint usage (O) within an eight week period (T).

Evidence: Seven high-quality studies met the inclusion criteria and found that a behavioral code team was an evidence-based practice. Behavioral code teams provide patient-centered care by providing a team of mental health professionals to respond to behavioral emergencies and promote a patient-centered treatment and support paradigm.

Intervention: Implemented and tracked a behavioral code team consisting of mental health professionals in an inpatient setting to assist with de-escalating disruptive behaviors and avoiding the use of mechanical restraints.

Outcome: The result of the two-tailed paired sample t-test was not statistically significant for the behavioral code team. However, the behavioral code team did result in clinical significance with an overall decrease in the number of mechanical restraints utilized during a behavioral emergency.

Conclusion: The behavioral code team provided a patient-centered care environment that ensured mental health professionals treated behavioral emergencies.

Behavioral Code Team

Rapid response teams are commonly used nationwide by hospitals to identify and respond to deteriorating patients outside the intensive care unit (Lyons et al., 2018). An extensive body of research is available, providing evidence of the effectiveness rapid response teams have on improving meaningful outcomes for patient populations (Lyons et al., 2018). Rapid response teams have become standard practice and have produced favorable results for patients located outside the intensive care unit throughout many healthcare organizations (Lyons et al., 2018).

In contrast, behavioral or psychiatric emergencies are not typically regarded as a medical or psychiatric concern but rather security threats. The security first paradigm is a nonclinical intervention that focuses on behavioral containment rather than treating mental health emergencies (Parker, 2019). Due to the national misconception of these psychiatric emergencies being perceived as a security threat, many healthcare organizations are ill-equipped to provide patient-centered care. As a result, numerous adverse clinical, workplace safety, and financial outcomes are generated (Parker et al., 2020).

The purpose of this evidence-based project was to implement and track a behavioral code team in an inpatient setting to assist with de-escalating disruptive behaviors and avoiding the use of mechanical restraints. The medical rapid response team concept and principles have recently been applied to non-medical emergencies involving behavioral and psychiatric crises (Zicko et al., 2017). These teams, referred to as behavioral code teams, respond similarly to the rapid response team, but the team is comprised of experts in the mental health field (Zicko et al., 2017). Behavioral and psychiatric emergencies can often present throughout an entire hospital and require professional mental health experts to respond (Lyons et al., 2018; Zicko et al., 2017).

Significance of the Practice Problem

In recent years, many concerns and debates have developed over the use of mechanical restraints in hospitals (de Bruijn et al., 2020). A rise in a medical, ethical, and political debate over the use of mechanical restraints on a patient admitted for medical care has provided a platform for discussion on whether the benefits of restraints outweigh their potential harm (de Bruijn et al., 2020). Restraints are often referred to as a necessary evil to keep a patient safe from harming themselves, but restraint usage carries a long list of potential harm and adverse outcomes (Gunawardena & Smithard, 2019).

The broad amount of potential harm associated with mechanical restraints is disturbing, for example, bedsores, malnutrition, incontinence, mental deterioration, and worsening of the behavior that led to the use of restraints (de Bruijn et al., 2020). Mechanical restraints have also led to severe injury or death by asphyxiation (Hine, 2007). In addition, medical professionals and patients alike have reported psychological effects of mechanical restraints, including fear, aggression, frustration, anger, and reduced engagement and apathy (Hine, 2007). Staff members have also reported that mechanical restraints on patients have led to the staff members feeling contentiousness and unhappiness (Chuang & Huang, 2007).

The frequency of mechanical restraints in an inpatient hospital setting has become common practice, which is not a result of any evidence-based practice (Gunawardena & Smithard, 2019). The United States has a mechanic restraint frequency in the acute care setting of 17 percent, with older adults making up most of the population (Gunawardena & Smithard, 2019). Several studies have found that utilizing a behavioral code team to de-escalate and re-direct patients has led to a 36.4% reduction in mechanical restraints (Prescott et al., 2006; Zicko et al., 2017). Patients with severe mental illness are at risk for adverse clinical outcomes while

admitted to a medical-surgical unit, despite the longer length of stays and additional hospital

resource utilization (Zolnierek, 2009). A study done by Daumit et al. (2016) discovered patients

with mental health disorders who were hospitalized in nonpsychiatric units were at a heightened

level of risk for a patient safety event or physical harm. The study reported that patients with

mental health disorders had 142 harmful physical events per 100 hospitalizations, which is

considerably higher than the general population, with 25 harmful physical events per 100

admissions (Daumit et al., 2016).

On the contrary, behavioral code teams have been found to decrease the use of

mechanical restraints, reduce the number of workplace violence incidents, decrease hospital

length of stay, resulting in less security and police interventions (Moore et al., 2019; Pinkhasov

et al., 2020; Smith et al., 2015; Zicko et al., 2017). Furthermore, the abundance of evidence

supporting the use of behavioral code teams persuaded the Department of Veterans Affairs to

reference the use of behavioral code teams across all VA healthcare facilities in the new national

Workplace Violence Prevention Program (WVPP) directive (Veteran Health Administration

[VHA], 2021). In accordance with the growing amount of evidence associated with adverse

events related to mechanical restraints and behavioral emergencies, the evidence-based project

reviewed the practice site behavioral restraint data and discovered during fiscal years 2019 and

2020, a total of 224 incidents occurred where a patient was placed in mechanical restraints due to

a behavioral issue.

The AMA Journal of ethics (2020) published a peer-reviewed article calling for the

switch from the security-driven paradigm employed by 21 state hospital associations, including

the evidence-based project practice site, to a more patient-centered treatment and support

paradigm (Parker et al., 2020). For instance, clinicians are commonly trained to call a rapid

response team for a medical emergency (Parker et al., 2020). Yet, clinicians are also commonly

trained to call a security code team for behavioral issues (Parker et al., 2020). The security code

team's primary purpose is to suppress imminent violence rather than promote patient-centered

treatment and support (Parker et al., 2020). Moreover, the practice of employing a security code

team discriminates against people diagnosed with psychiatric disorders, which then cascades into

poor clinical judgment, workplace violence, and adverse financial outcomes. (Parker et al.,

2020).

The unbalanced treatment for the patient experiencing a mental health crisis to those

experiencing a more common medical emergency has received national attention from several

groups, including The Joint Commission (TJC). The Joint Commission R3 report announced the

new requirement for workplace violence prevention standards that will go into effect on January

1, 2022, for all accredited hospitals and critical access points throughout the United States (The

Joint Commission [TJC], 2021a). The new standards require the organizational setting to provide

training, education, and resources to prevent workplace violence, including creating a

multidisciplinary committee with a focus on policy and procedures to prevent and respond to

workplace violence (TJC, 2021a). The Joint Commission R3 report also emphasizes the

importance of utilizing best practices and evidence-based research to support de-escalation

techniques, nonmechanical intervention skills, mechanical intervention techniques, and response

to emergency incidents (TJC, 2021a).

The new workplace violence standards were created in response to the growing data

showing that healthcare workers were five times more likely to experience workplace violence

than all other workers (TJC, 2021a). The workplace violence prevention standards also

emphasize knowing one's role during a behavioral emergency, such as leadership, clinical staff,

security, and hospital law enforcement (TJC, 2021a). Implementing a behavioral code team has assisted this healthcare organization meet many of the JTC's new workplace violence standards. Therefore, behavioral code teams should be considered an evidence-based treatment for the behavioral disruptive patient population.

PICOT Question

The PICOT that guides this project is: *In the Veteran patient population admitted to acute inpatient services (P), how does having a behavioral code team respond to behavioral emergencies (I) compared to the current practice (C) affect the prevalence of mechanical restraint usage (O) within an eight week period (T).*

The evidence-based project was implemented at a Veteran Administration (VA) medical facility in southern California. The facility is a tertiary care medical center classified as a Clinical Referral Level 1a facility (U.S. Department of Veterans Affairs [VA], 2020b). The facility provides comprehensive care to various inpatients and outpatients, totaling more than 50,000 Veterans (U.S. Department of Veterans Affairs [VA], 2020a). The evidence-based project focused on the preventative use of mechanical restraints in the acute inpatient units with a primarily geriatric patient population.

The intervention of the evidence-based project involved implementing a behavioral code team in the acute inpatient setting. During administration hours of 8:00 am to 4:30 pm, the behavioral code team consisted of two nurses from the mental health department, a psychiatrist, two VA police officers, and a social worker. During non-administration hours from 4:30 pm to 8:00 am, the behavioral code team consisted of two nurses from the mental health department, a mental health nocturnist doctor, two VA police officers, and the nursing officer of the day (NOD). The team comprised five positions: team leader, communicator/de-escalator, situation-

background-assessment-recommendation (SBAR) nurse, medication nurse, and safety monitor. Unit staff requesting the behavioral code team was expected to remain present and available to assist the behavioral code team and the five roles. Research has shown it's essential for behavioral code team members to be flexible with the team's composition and which roles each member will be responsible for fulfilling in the behavioral emergency (Snorrason & Bering, 2018). The VA police were secondary members and intervened once the situation became dangerous to staff, patients, or visitors. The team leaders were the healthcare professionals attempting to calmly de-escalate the situation by utilizing skills learned in the VA Prevention and Management of Disruptive Behavior (PMDB) program (Appendix A). The behavioral code team was called using the standards and process set forth by the evidence-based project outline (Appendix B) to support staff during a disruptive behavioral patient to de-escalate the situation with minimal use of mechanical restraints. Other unit members trained in the PMBD program also participate and assist the behavioral code team with the de-escalation or therapeutic containment. The behavioral code team was on the unit to assist, not take over, unless necessary.

Historically, the facility has not used a behavioral code team in daily practice to de-escalate behaviorally disruptive patients. Therefore, the comparison data was the number of restraints used in the acute inpatient setting during the previous two months when the behavioral code team was not used. The predicted outcome was a decrease in mechanical restraints used on the patient population within the acute inpatient setting. The behavioral code team was implemented and evaluated in acute inpatient units in an 8-week span of time. During the 8-weeks, the behavioral code team intervention was monitored, evaluated, and refined to meet the requirements for a best practice environment.

Evidence-Based Practice Framework & Change Theory

The evidence-based project utilized the Johns Hopkins Evidence-Based Practice (JHNEBP) model to empower the project's problem-solving approach to the PICOT question (Dang & Dearholt, 2018). The JHNEBP model utilizes a three-step PET process, which stands for practice question, evidence, and translation (Dang & Dearholt, 2018). The model's objective is to quickly locate best practices and appropriately incorporate them into patient care (Dang & Dearholt, 2018).

The practice portion of the PET process begins with assembling an interprofessional team to examine specific concerns related to de-escalating disruptive patients and the widespread use of restraints (Dang & Dearholt, 2018). The interprofessional stakeholder team developed a comprehensive understanding of the practice problem through meeting and timeline development and developed refined evidence-based questions for the project (Dang & Dearholt, 2018). The evidence portion of the PET process involved completing a literature search and evaluating the levels and grades of evidence that supports the PICOT question guiding this project (Dang & Dearholt, 2018). The final stage consists of the translation phase, which involves interpreting the evidence phase into an EBP change project and evaluating the results in the desired patient care setting (Dang & Dearholt, 2018).

The change theory that guided the evidence-based project projects was the Prosci ADKAR model (Prosci, n.d.). The word "ADKAR" is an acronym for the outcomes that need to be achieved to have a successful change project (Prosci, n.d.). The five outcomes required are (1) awareness, (2) desire, (3) knowledge, (4) ability, and (5) reinforcement. The theory was created with the understanding that an organizational change can only occur when individuals within the

organization understand and support the evidence-based change (Prosci, n.d.). The employees

must understand the importance of the organizational change, from which a desire to participate

will be formulated (Prosci, n.d.). The evidence-based project outlined the available resources to

ensure participating stakeholders will have the ability to be successful (Prosci, n.d.). Lastly, it is

essential to reinforce the continued need for the evidence-based change project to sustain the

change (Prosci, n.d.).

Evidence Search Strategy

A literature search was conducted for the evidence-based project by utilizing Nursing and

Allied Health (CINAHL), Publisher MEDLINE (PubMed), and Ovid MEDLINE databases. The

keywords used in the search consisted of behavioral emergency, behavioral code team, crisis

intervention, emergency response team, rapid response, and restraints. The inclusion criteria

were limited to academic journals, English speaking, and a date range from 1995 to 2021. The

CINAHL database was searched using the keywords (behavioral code team) or (rapid response

team) and (restraints). The OVID MEDLINE database was searched using the keywords (crisis

intervention) and (restraints). Lastly, a search of the PubMed database was performed with the

keywords of (rapid response) and (behavioral), and (restraints).

The exclusion criteria were articles that did not discuss the use of emergency response

teams to de-escalate behavioral emergencies and decrease the use of mechanical restraints. In

addition, medical conditions other than behavioral, such as a rapid response for chest pain, were

excluded. After reviewing the abstract, articles were excluded for being summary articles and

secondary resources.

Evidence Search Results

The evidence-based project's database search strategy resulted in evidence to support the use of behavioral code teams to de-escalate behavioral disturbances in a hospital setting. CINAHL database search resulted in 45 articles, OVID MEDLINE resulted in 19 articles, and PubMed resulted in 2 articles (Figure 1). The total number of articles after duplicates were removed was 64. A thorough review of the literature abstracts concluded that 45 articles focused on alternative medical issues other than behavioral and were excluded from the project. The full-text article reviewed concluded that 19 articles should be excluded for a patient population younger than 18 years of age, educational material, quality improvement articles, and focusing on non-hospital settings such as local neighborhoods or cities. The remaining seven articles provided sufficient evidence to support the project and were evaluated for level and quality using the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal tool (Appendix C).

The seven articles were all primary sources that consisted of 3 qualitative designs with a Johns Hopkins Level III grade of A/B (Appendix D). The remaining 4 articles were quantitative research designs with level II/III grade A/B for quality design (Appendix D). Details of the reduction strategy are depicted in the Prisma flow diagram (Figure 1).

Themes with Practice Recommendations

The evidence-based project thoroughly reviewed the literature and identified three main themes of the evidence to substantiate EBP recommendations. The Johns Hopkins Evidence-Based Practice tool was utilized to identify quality evidence-based resources. The literature review produced three common themes, which are (1) utilization of a specialized trained behavioral code team for behavioral emergencies, (2) interprofessional collaboration within the

behavioral code team, and (3) de-escalation techniques to reduce the need for mechanical

restraints (Digby et al., 2020; Godfrey et al., 2014; Moore et al., 2019; Pinkhasov et al., 2020;

Snorrason & Biering, 2018; Wong et al., 2015).

Utilization of a Specially Trained Behavioral Code Team

All the studies reviewed for the evidence-based project specifically mentioned using a

specially trained behavioral code team to assess and assist with behavioral emergencies in a

multitude of settings. For example, Snorrason and Biering (2018) refer to the team as De-escalate

and Restraint Patients with Aggression (D-E&R) team, and Digby et al. (2020) referred to the

team as a Psychiatric Behaviors of Concern (Psy-BOC) response team (Digby et al., 2020;

Snorrason & Biering, 2018). On the other hand, the Moore et al. (2019) study simply referred to

the Behavioral Response Team (BRS). Still, the team's title made little difference; the behavioral

code team was developed and specially trained to respond to a behavioral emergency within an

inpatient hospital setting (Moore et al., 2019). The goal of a behavioral code team is to safely de-

escalate the situation with the least restrictive method possible (Moore et al., 2019).

Interprofessional Collaboration

The characteristics of a behavioral emergency response differ slightly in aspects of the

size of the team, but the general theme of the teams remained consistent throughout the

literature. The behavioral code team was developed with key members such as nursing

supervisors, psychiatric nurses, medical or psychiatric doctors, and hospital police officers

(Wong et al., 2015). A more significant finding in the literature expressed the importance of

interprofessional collaboration, strong leadership, confidence in team performance, clear

communication, and flexibility in team composition and skill set (Digby et al., 2020; Moore et

al., 2019; Snorrason & Biering, 2018). A behavioral code team is a shining example of the

effectiveness and importance of interprofessional collaboration in cases of extreme emergencies to produce the most favorable patient outcomes.

De-escalation Techniques to Reduce the Need for Mechanical Restraints

A consistent theme throughout the literature was the importance of de-escalation techniques, and how, if used correctly, they lead to a decrease in mechanical restraints during and after a behavioral emergency (Godfrey et al., 2014; Moore et al., 2019). The de-escalation training included critical elements such as therapeutic communication skills, supportive patient interaction, early identification of behavioral deterioration, and the importance of delineation of roles during a behavioral emergency (Digby et al., 2020; Pinkhasov et al., 2020; Wong et al., 2015). Each study, at one point, discussed the need for a specialized structured training program for proper usage of verbal de-escalation techniques, pharmacologic administration, and, if needed, the proper use of mechanical restraint (Pinkhasov et al., 2020; Wong et al., 2015). The literature overwhelmingly agreed with using a properly trained group of professionals in the skill sets needed to de-escalate a behavioral emergency safely.

Practice Recommendation

The current practice recommendations are founded based on the conclusion of the synthesized evidence-based research designs, which incorporated the use of behavioral code teams in an inpatient setting, the importance of interprofessional and multidisciplinary involvement with the behavioral code team, and specialized training for staff in the field of de-escalation techniques. The evidence-based practice recommendations enforce vital elements of a successful behavioral code team that fosters a team dynamic of confidence, trustworthiness, safety, and effective communication, which enable the team to present a united front during a behavioral emergency (Snorrason & Biering, 2018). The evidence-based project collaborated

with the medical facility's leadership to ensure proper support and sustainability of the practice

recommendations. An abundance of evidence emphasizes the importance of leadership support

and collaboration for a successful evidence-based practice implementation (Parker et al., 2020).

Although the practice recommendations are guidelines for forming a successful behavioral code

team, the actual dynamic of the team may differentiate between organizations based on the

organization's available resources and staff.

Setting, Stakeholders, and Systems Change

The evidence-based project's setting was in a large, diverse tertiary medical facility

comprised of complex, inpatient, outpatient, and extended care programs for patients throughout

southern California (County of Los Angeles, 2021). The healthcare organization employs 2,200

full-time employees, covering the care for over 50,000 Veterans in the Long Beach area and

surrounding cities (County of Los Angeles, 2021). The evidence-based project's setting had

several different services offered to the patient population, such as medicine, surgery, psychiatry,

mechanical medicine and rehabilitation, neurology, oncology, dentistry, spinal cord injury,

geriatrics, blind rehabilitation, and extended care services (VA, 2020b). The healthcare facility

authorized bed compacity consists of a bed total of 247, with an additional 90 beds for the spinal

cord and 99 beds for geriatric and nursing homes (VA, 2020b). The evidence-based project

focused on acute inpatient care services.

The practice setting for the evidence-based project had developed an interdisciplinary

stakeholder committee called the Disruptive Behavior Committee (DBC). The DBC operates

under the chief of staff (COS) authority and consists of a diverse population of healthcare

professionals and related hospital operational leaders such as hospital police officers, social

services, nursing leadership, emergency management department, quality management, and is

chaired by a medical clinician (VHA, 2021). The DBC is responsible for using evidence-based

and data-driven practices to prevent, identify, assess, manage, reduce, and track patient-

generated disruptive behavior (VHA, 2021). Thus, the members of the DBC were key

stakeholders in the entire evidence-based project.

The ADKAR change theory was utilized to uphold the evidence-based project's integrity,

reliability, and sustainability. The awareness, desire, knowledge, ability, and reinforcement of

the evidence-based project were achieved by interacting and involving the Veteran Health

Administration's (VHA) Workplace Violence Prevention Program (WVPP) and personnel

(VHA, 2021). The WVPP is a VA program that provides the foundation for stakeholders to

implement, track and support evidence-based and data-driven practices for preventing,

identifying, assessing, managing, reducing and tracking patient-generated disruptive behavior

(VHA, 2021).

The evidence-based project was deemed a mesosystem change because the project

involved several units working together to create a hospital change (Likosky, 2014). A SWOT

analysis was conducted for the mesosystem change at the practice site (Appendix E). Several

areas were identified for internal strengths and weaknesses, and a review of external

opportunities and threats was conducted. The evidence-based project had support from the

practice site nursing leadership and several other critical departments, such as the Quality,

Safety, & Value department. The practice site also had several committees, such as the DBC,

focusing on preventing and responding to workplace violence, which was utilized to engage

stakeholders and support the evidence-based project. In addition, the evidence-based project had

opportunities to decrease sentinel events throughout the practice site and enhance patient and

staff safety.

Unfortunately, the practice site did suffer from external threats such as a COVID-19

surge slowing new proposals and projects. Also, staff turnover or unplanned leave led to

interruptions in the project's progress. Fortunately, many threats were mitigated through proper

planning and proactive implementation of the evidence-based project's objectives.

Implementation Plan with Timeline and Budget

Project Objectives

The evidence-based project's preferred outcome was to decrease mechanical restraints on

patients in the acute inpatient setting by utilizing the behavioral code team. Therefore, the

evidence-based project's short-term objectives were to first focus on receiving approval for the

project from the University of St. Augustine's Evidence-Based Practice Review Council (EPRC)

and the medical facilities' s Investigational Review Board (IRB). Once permission was granted

for the project, the focus was on achieving the goal of developing and implementing a behavioral

code team. The evidence-based project aimed to develop and utilize a behavioral code team to

focus on disruptive behavioral emergencies in the inpatient setting and provide patient-centered

care, which would decrease the use of mechanical restraints. The intervention began on

December 7, 2021. The goal was achieved by completing several objectives that involve

procedure elements, such as receiving approval of the evidence-based project's outline from the

medical facility's executive leadership team (Appendix B) and ensuring staff is compliant with

the medical facility's Prevention and Management of Disruptive Behaviors level I to III courses.

Follow-up meetings were conducted with stakeholders to ensure the team dynamic of the

behavioral code team was cohesive with the available resources at the medical facility. In

summary, the evidence-based project's short-term goals consisted of the following:

1. Receive approval of the evidence-based project's outline for the behavioral code team prior to implementing the evidence-based project (Appendix B).

2. The team composition of the behavioral code team was confirmed immediately following approval of the evidence-based project by meeting with stakeholders and ensuring the behavioral code team is comprised of available resources.

3. Ensured participating staff complied with the medical facility's Prevention and Management of Disruptive Behavior (PMDB) courses, levels I-III, before implementing the evidence-based project.

The evidence-based project's long-term goals consisted of completing objectives to ensure the project's outcomes were achievable and measurable.

Long term objectives:

1. Prior to implementing the evidence-based project, all acute inpatient areas had access to and understood the behavioral code team.

2. 95% or greater behavioral response team data with outcomes was collected for each behavioral code team call within an 8-week period.

3. Decreased mechanical restraint use in the acute inpatient setting.

The disruptive behavior committee (DBC) played a significant role in developing and completing the evidence-based project's short-term and long-term objectives. Per the VA national WVPP directive, the DBC is a facility-level, interdisciplinary committee whose primary task is to promote evidence-based and data-driven practices to prevent, identify, assess, manage, reduce, and track patient-generated disruptive behavior (VHA, 2021). The evidence-based project required the participation of the DBC to confirm evidence and assist with the implementation of this evidence-based recommendation.

Implementation Plan

The PET process of developing a practice question, collecting the evidence, and then translating the information into best practice was a critical component of the evidence-based project process (Dang & Dearholt, 2018). The evidence-based project began with developing the practice question by meeting with a multidisciplinary team of stakeholders to discuss the challenges of behavioral emergencies at the practice site. Next, a practice question was formulated, followed by an extensive search and review of the literature related to the practice question. Lastly, the literature was translated into a comprehensive best-practice plan implemented at the practice site.

The ADKAR change theory was utilized in the development of the evidence-based implementation plan. ADKAR was a valuable framework for the development and success of an evidence-based practice change. The ADKAR change theory involves the implementation of 5 steps, which are (1) awareness for change, (2) desire to participate and support change, (3) knowledge of change, (4) the ability to implement change, and (5) reinforcement to keep the change (Prosci, n.d.).

The initial awareness of the change process began during the planning phase of the evidence-based practice project. While assessing the practice site of the evidence-based project, a clear and present danger to staff and patients was identified by leadership due to the absence of a behavioral code team. Also, the R3 Report from TJC highlights the fact that health care and social services workers are five times more likely to experience workplace violence (TJC, 2021a). Therefore, TJC is mandating the implementation of policies, procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence on January 1, 2022 (TJC, 2021a).

The support for the behavioral code team began with leadership recognizing the workplace violence issue within the facility. Next, additional support arises from the literature review providing evidence-based recommendations for creating and implementing a behavioral code team to decrease workplace violence and the use of mechanical restraints (Zicko et al., 2017). Additional critical support elements came from frontline staff, such as nurses and social workers, requesting additional support during a behavioral emergency inside the hospital. The final piece of support came from the VA national directive entitled VHA Workplace Violence Prevention Program, which was published on August 23, 2021 (VHA, 2021). The directive references behavioral code teams throughout VA medical centers to respond to and prevent workplace violence (VHA, 2021).

Knowledge and the ability to implement change were supported by the evidence-based project through the executive leadership team, nursing leadership, the nursing education department, the quality management department, and members of the DBC. The support of these critical departments helped disseminate the behavioral code team knowledge and provided the ability to implement the evidence-based project's change. The evidence-based project utilized the Prevention and Management of Disruptive Behavior (PMDB) program to train and educate the behavioral code team in skills of de-escalation, limit setting, and therapeutic containment (VHA, 2021). The PMDB program was the only curriculum approved for mandatory training of all VHA personnel in concepts of workplace violence prevention and directly discussed the development and use of a behavioral code team (Appendix A). In addition, the PMDB courses were mandatory for all employees working in high-risk violence areas, such as the psychiatric department and emergency department. Therefore, the behavioral code team members should have already completed these courses during the hiring process. The project manager confirmed

the behavioral code team members were compliant with their PMDB training. Lastly, the

successful implementation of the first three steps of ADKAR change theory provided the

foundation for step five, "reinforcement to keep the change." (Prosci, n.d.).

The ADKAR change theory framework, if followed appropriately, develops the support

and resources needed to reinforce the change process. The behavioral code team data was

collected and stored by the DBC. In addition, the behavioral code team data was distributed

among the nursing leadership to post on the unit's daily data management system boards,

referred to as huddle boards. The huddle board system provided a consistent and simple format

to disseminate information throughout the hospital and allowed for transparency throughout the

evidence-based project.

Timeline and Budget

The evidence-based project was planned for eight weeks, allowing time for adjustment if

required (Appendix F). The evidence-based project did not begin until the Evidence-Based

Practice Council (ERPC) and the institution's Investigational Review Board (IRB) had approved

the proposal. The Doctor of Nursing Practice (DNP) student acted as the project manager and

worked with stakeholders, such as the DBC, to ensure adequate leadership and frontline staff

involvement. Stakeholders were provided consistent communication by the project manager to

ensure adequate team communication and feedback. Baseline restraint data were collected two

months before the start of the evidence-based project. After which, restraint data was collected

every month (Appendix G). In addition, data were collected at each behavioral emergency

through a documented debriefing form, including the events leading up to the behavioral

emergency and the outcome (Appendix H). The debriefing form was explicitly created to capture

the required data needed for the evidence-based project outcome measures. The debriefing forms

were collected for analysis on a weekly basis (Appendix I). To assess the face validity of the

debriefing form, the evidence-based project included teaching members the proper usage of the

debriefing form with a return demonstration to confirm accuracy and consistency in using the

tool. In addition, weekly audits of the debriefing forms were completed to confirm the consistent

and proper application of the form. After each behavioral emergency response, the team

debriefed and discussed the entire experience and how the experience could be improved. The

evidence-based project paid close attention to the use of restraint data throughout the acute

inpatient units and how the evidence-based project impacted the use of restraints. The

documented debriefing sheets (Appendix H) provided valuable data and allowed for feedback

and corrective training as needed for stakeholders.

The evidence-based project utilized the VA staff to be on the behavioral code team. The

education and staff training for inpatient units were incorporated in the budget plan developed

during the staffing methodology unit projects. Therefore, the evidence-based project did not

exceed the unit-based budget for staff education and training. Staff training for PMBD was

completed during the hiring process. The VA Police Department utilized available department

resources and did not acquire additional costs during the evidence-based project. The plan

incorporated the use of officers already on duty. The total approximate cost was $5,700 (Table

1).

Results

The behavioral code team intervention was monitored and evaluated through a pre-and

post-intervention plan. The practice site provided baseline data prior to approval for

implementation of the evidence-based project, from which impending post-intervention data

established a comparison. The intervention data was collected through the post-behavioral code

team's debriefing forms, including describing the events that precipitated the behavioral

emergency and the outcome post-intervention by the behavioral code team (Appendix H). The

evidence-based project remained HIPAA compliant using patient identifier numbers, storing the

debriefing forms in a locked government file, and deposing the debriefing form from the practice

site once the data has been transcribed onto an encrypted government laptop.

      The primary outcome metrics were expressed by the number of restraint usage in the

acute inpatient floors where the behavioral code team is implemented. The determination of a

relationship between the intervention and outcome was established by collecting the baseline

data of restraint usage from the Office of Data Collection and Analysis (ODCA). The ODCA is

the VA department responsible for collecting and storing unit and hospital-wide data. In

addition, the ODCA department can extract behavioral restraint orders from the practice site's

computerized patient record system (CPRS), which in turn will provide the total pre and post-

behavioral restraint data for the measurable outcome (Appendix G). In addition, the behavioral

restraint data was analyzed and verified by the practice site's Restraint and Seclusion Committee

every month.

      The short-term objective of receiving approval for the behavioral code team's outline was

confirmed by receiving an approval letter from the practice site executive leadership. The

evidence-based project required the short-term goals to be accomplished before implementing

the behavioral code team interventions. The long-term objectives were completed by weekly

evaluation to ensure 95% or greater compliance with the post-debriefing forms for each

behavioral code team intervention. The weekly evaluations of debriefing forms allowed time for

corrective action concerning the behavioral code team's response to an emergency. The

debriefing forms were examined for compliance and opportunities for corrective training. In

addition, data was gathered on the behavioral emergency's outcome, specifically if mechanical restraints were used during the intervention.

The evidence-based project may have had several unintended consequences due to the implementation proposal but was mitigated with proper planning. First, an evaluation plan was implemented to ensure proper balancing of resources, including monitoring for adverse events on the behavioral code team's home units when the staff is off the unit responding to a behavioral emergency. For example, an increase in a medical or behavioral emergency was monitored through the medical facility emergency log and compared with the data obtained from the behavioral code team debriefing form. Second, a financial element of the evidence-based project was monitored by utilizing the psychiatric units staffing methodology business proposal. The medical facility has a financial set limit for each inpatient unit, including funds for education and training. The evidence-based project monitored weekly overtime related to training for the evidence-based project and staffing purposes for the behavioral code team on the member's home units. The outcome was no additional overtime was required for training or staffing the response team. Also, staff and patient injuries were documented on the debriefing forms to track adverse events. Finally, the evidence-based project implemented the pre-and post-intervention design to capture the data of unintended consequences such as the number of adverse events and the financial impact of the project's implementation. The evidence-based project resulted in zero financial or unit-based adverse events during implementation, which provided additional support for the continued use of the behavioral code team.

Analysis

The evidence-based project relied on inferential statistics for the pre-and post-intervention. A two-tailed paired sample t-test was used to determine if the evidence-based

project intervention has developed a significant difference between the pre-and post-data

collection. The evidence-based project tracked compliance with a weekly audit of the behavioral

emergency debriefing forms. The restraint data were observed monthly and compiled into

different time data sets showing decreased or increased restraint usage post-intervention and

stored within the practice site Restraint and Seclusion Committee's secured government

SharePoint (Appendix G). The debriefing form data was collected and analyzed weekly to

observe the location and outcome of the behavioral emergency (Appendix I). The analysis was

completed using statistical software with the assistance of a statistician. The evidence-based

project's outcome measure is considered statistically significant, with an outcome of less than or

equal to p = 0.05.

The evidence-based intervention was implemented on December 7, 2021, and the final

data collection concluded on January 31, 2022. Pre-data collection was obtained for October and

November 2021, with the post-intervention months of December 2021 and January 2022. The

result of the two-tailed paired samples *t*-test from October (pre-intervention) to January (post-

intervention) was not significant based on an alpha value of .05, $t(8) = 1.06$, $p = .319$. The

finding suggests that the difference in the mean of restraints between October 2021 and January

2022 was not significantly different from zero. The two-tailed paired sample test for the pre-post

intervention months December 2021 and January 2022 was not significant based on an alpha

value of .05, $t(8) = 0.67$, $p = .521$. This finding suggests the difference in the mean use of

restraints in December 2021 and the mean use of restraints in January 2022 was not significantly

different from zero.

The evidence-based intervention did not have statistical significance due to the small

sample size (Appendix I) but does have clinical significance due to a substantial decrease in

overall restraint usage throughout January, leading to a four-month low of inpatient restraint usage of a total of 60 patients in restraints, compared to October restraint usage of 97 patients in restraints (Appendix G). Pre-intervention mean restraint usage for October 2021 was 10.78. Post-intervention mean restraint usage for January 2022 was 6.67, a substantial decrease in the number of restraints used on an average basis for the practice site (Appendix J). The behavioral code team response data revealed a total of 12 behavioral emergencies; 33.33% resulted in a verbal redirection intervention, 16.67% resulted in a PRN medication intervention, and only 16.67% resulted in a mechanical restraint intervention (Appendix K). The evidence-based intervention resulted in an overall decrease in restraint usage throughout the acute inpatient units the team was deployed for a behavioral emergency.

The preferred outcome was a decline in restraints in the acute units where the behavioral code team was implemented. The evidence-based project considers any decrease in restraint usage in these acute units to be a clinically significant finding. The evidence-based intervention data provide clear evidence of a clinically significant decrease in the amount of restraint utilized post-intervention. The importance of implementing new and innovative evidence-based strategies for addressing mental health issues in the United States healthcare system is essential and significant to ensure patient-centered care is provided.

Impact

The purpose of this evidence-based project was to implement and track a behavioral code team in an inpatient setting to assist with de-escalating disruptive behaviors and avoiding the use of mechanical restraints. The increased use of mechanical restraints throughout the United States healthcare systems has led to a rise in medical, ethical, and political debates (de Bruijn et al., 2020). Simultaneously, healthcare workers are at an all-time high for workplace violence

incidents (TJC, 2021a). The workplace violence in healthcare has led TJC to release a new set of

standards requiring accredited hospitals to provide training, education, and resources to prevent

workplace violence, including creating a multidisciplinary committee with a focus on policy and

procedures to prevent and respond to workplace violence (TJC, 2021a). The evidence-based

project's intervention directly impacted the critical, ethical, and political factors facing the

practice site's organization.

      The evidence-based project was a challenging but worthy intervention to implement

throughout the practice site. The broad number of stakeholders created a complex web of

interrelated, multidisciplinary departments that required various meetings and presentations to

understand the importance of the evidence-based project. Implementing a behavioral code team

to respond to behavioral emergencies throughout an acute inpatient setting required a culture

change for the entire organization. Creating this culture change required support from the

organization's executive leadership team, police department, and buy-in throughout the entire

nursing services and the psychiatric and medical physicians. The practice site had a security first

paradigm mindset; a nonclinical intervention focused on behavioral containment rather than

treating the mental health emergency. The evidence-based project's stakeholder interaction

focused on changing the security first paradigm into a patient-centered treatment and support

paradigm focusing on treating the behavior (Parker et al., 2020). The evidence-based project

successfully created a culture change through stakeholder interactions and by ensuring a

meaningful post-debriefing meeting was conducted after each behavioral emergency—the

evidence-based project implemented a mindset of treating these behavioral emergencies as

clinical emergencies.

The evidence-based project was implemented during the Omicron coronavirus variant

national surge, which created a national healthcare staffing shortage. The evidence-based

project's SWOT analysis predicted the coronavirus as a possible threat that would result in a

national staffing crisis. Fortunately, the evidence-based project was prepared to implement under

stressful conditions by adequately planning for such an event. The Omicron coronavirus surge

created a significant national staffing crisis, which led to limited resources throughout the

practice site. The continued success and implementation of the behavioral code team during a

coronavirus surge and staffing crisis provided additional evidence the intervention could be

completed with limited impact on hospital resources. The Omicron surge provided a challenging

clinical environment for the evidence-based proposal. It provided additional evidence that a

behavioral code team can be a successful intervention with limited resources during a national

crisis.

The evidence-based project will require continued support from the practice site's

leadership, including the executive leadership team and nursing services, to implement a

permanent evidence-based culture change of a behavioral code team. The nursing leadership of

the mental health department will act as champions for the evidence-based project to ensure

continued implementation of the behavioral code team, which is similar to how the nursing

leadership of the intensive care unit is the champion for the rapid response team. The nursing

leadership of the mental health department will continue to lead the ongoing implementation of

the behavioral code team and support the team's interventions.

Dissemination Plan

The conclusion of the evidence-based project was shared with the nursing leadership and

appropriate stakeholders at the nursing leadership committee (NLC). At the NLC, a PowerPoint

presentation was utilized to celebrate the accomplishments and review areas for improvement.

Due to continued COVID-19 regulations, the PowerPoint presentation utilized Microsoft Teams

to dismantle the evidence-based project's conclusion to the NLC. In addition, all pertinent data

and processes were supplied to the DBC members for further evaluation and dissemination for

possible stakeholders who could not attend the final evidence-based project presentation. The

Daily Data Management System, referred to as Huddle Boards, reached a broader audience

throughout the medical facility by posting relevant information for unit staff to review. The

Daily Huddle Boards are located in each hospital unit and are utilized as a format to provide the

nursing staff with helpful and interesting hospital information and data. The evidence-based

project utilized the Daily Huddle Board system to disseminate the accomplishments of the

evidence-based project and build an understanding of the project's ability to assist nursing staff

with patient-centered care. Furthermore, the results were shared with the University of St.

Augustine's Scholarship and Open Access Repository (SOAR), which collects and stores

scholarly publications for peers and faculty to review and discuss. Lastly, the evidence-based

project was distributed through the Sigma Theta Tau International repository to reach a broader

scope of peers at a national and global level.

Conclusion

The medical rapid response team (RRT) became a standard of care throughout the acute

care hospitals in the United States in 2004 (Parker et al., 2020). RRTs advance medical care by

proactively identifying deteriorating patients and providing team-based stabilizing treatment to

prevent continued decompensation (Parker et al., 2020). An abundance of recent evidence-based

research has proven the same RRT concept can be applied to behavioral emergencies with

favorable outcomes for patients and hospital staff, including reducing the use of mechanical

restraints. The research over the past decade has provided evidence-based best practice guidelines for the reduction of mechanical restraint during a behavioral emergency, which includes the development of a multidisciplinary behavioral response team consisting of a variety of healthcare professionals and essential stakeholders (Smith et al., 2015; Zicko et al., 2017).

The Joint Commission has brought workplace violence to the forefront of the 2022 review of accredited and critical care access hospitals, including requiring leadership oversight, policies and procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence (TJC, 2021a). The evidence-based project directly responds to the current available research and requirements of medical facilities to address behavioral emergencies as vigorously as the facility would a medical emergency. The evidence-based project aims to ensure patient-centered care is provided during these behavioral emergencies and reduce the prevalence of medical staff possibly unjustly mechanically restraining a patient having a psychiatric crisis.

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Table 1

Budget

EXPENSES		REVENUE	
Direct		Billing	N/A
Salary and benefits	$5,200	Grants	N/A
Supplies	$100	Institutional budget support	$9,500.00
Services	$100		
Statistician	$300		
Indirect	0.00		
Overhead			
Total Expenses	$5,700	Total Revenue	$9,500.00
Net Balance			$3,800

Figure 1: Literature Search PRISMA Diagram
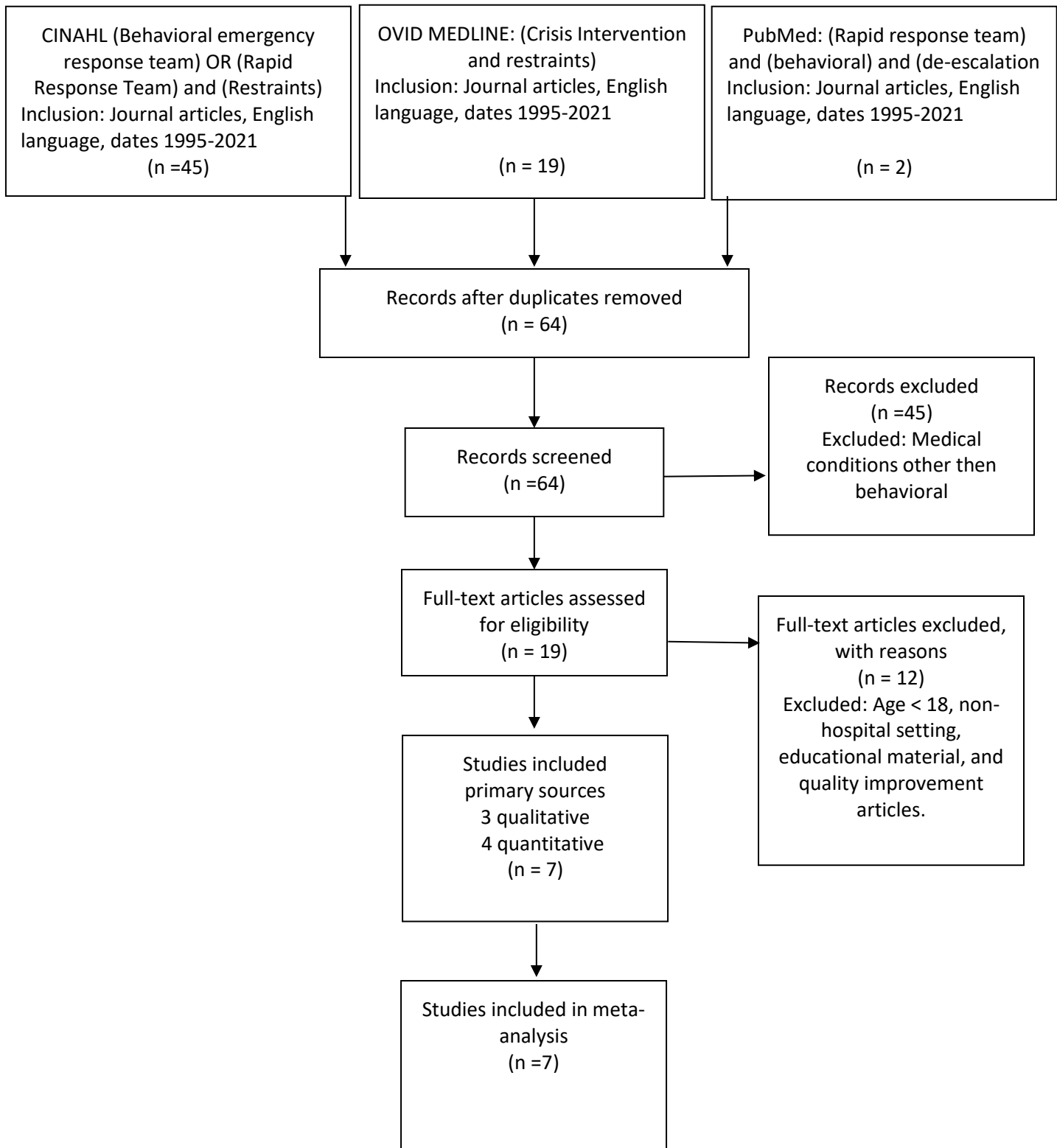
Appendix A

Prevention and Management of Disruptive Behavior Program (PMDB)

PMDB Facility Courses	Content	Frequency	Target Audience	TMS Item Number	Existing Curriculum Substitutes
Part 1	Overview of Workplace Violence Prevention including Identifying Levels of Stress and Appropriate Staff Interventions, and Sexual Assault Prevention Awareness Training. (Online or In Class: 1 hour)	Once and done	All Employees	Online VA 37659 (Non-Accredited: 1 hour) Classroom Alternative VA 39708 (Non-Accredited 1 hour) Virtual Classroom Alternative VA 42922 (Non-Accredited 1 hour)	VA 7831 and 16699 (PMDB Level 1) VA 23805 (PMDB Level 2A)
Part 2 Low Risk	Observation, Assessment, and Verbal De-escalation Skills Training to address Verbal Disruptive Behaviors in the Workplace (In Class: 2 hours) CEUs available for licensed staff upon completion of evaluation.	Once (Only return to class if unable to pass Skills Assessment)	Employees in Low, Moderate, and High-Risk Workplaces	VA 39522 (Accredited 2 hours) Virtual Classroom Alternative VA 42923 (Accredited 2 hours)	VA 12509 PMDB Level 2 Track 1 or VA 24012 PMDB Level 2B

Part 2 Mod/Hi Risk	Observation, Assessment, and Verbal De-escalation Skills, including Verbal Limit Setting Skills Training, and Personal Safety Skills Training to address Physical Disruptive Behaviors in the Workplace (In Class: 4 hours) CEUs available for licensed staff upon completion of evaluation.	Once (Only return to class if unable to pass Skills Assessment)	Employees in Moderate and High-Risk Workplaces	VA 39523 (Accredited 4 hours) Virtual Alternative VA 43661 (Accredited 3 hours) **and** In-Person VA 43655 (Accredited 1 hour)	VA 12509 PMDB Level 2 Track 1 **and** VA 12510 PMDB Level 3 Track 1 VA 24012 PMDB Level 2B Track 2 **and** VA 24273 PMDB Level 3 Track 2
Part 3	Therapeutic Containment Skills to Train Employees in the Safe Containment of an Actively Physically Violent Patient (In Class: 4 hours) CEUs available for licensed staff upon completion of evaluation.	Once (Only return to class if unable to pass Skills Assessment)	Only Clinical Employees in High Risk Workplaces	VA 39716 (Accredited 4 hours)	VA 12511 PMDB Level 4
Verbal Skills Assessment	Provides an opportunity for employees with initial Part 2 Low and Part 2 Mod/High for a "test out" to complete training renewal requirements. If not successful, employees are reassigned Part 2 courses.	Every 2 years	Employees who have completed Part 2 Low or Part 2 Mod/High or Level II courses	VA 24807 Virtual Alternative VA 43715	N/A
Physical Skills Assessment	Provides an opportunity for employees with initial Part 2 Mod/High for a "test out" to complete training renewal requirements. If not successful, employees are reassigned Part 2 Mod/High course.	Every 2 years	Employees who have completed Part 2 Mod/High or Level III courses	VA 24808	N/A

Containment Skills Assessment	Provides an opportunity for employees with initial Part 3 for a "test out" option to complete training renewal requirements. If not successful, employees are reassigned Part 3 course.	Every 2 years	Employees who have completed Part 3 or Level IV	VA 24809	N/A
Train the Trainer (TTT) Course		Once	Employees who wish to become certified PMDB Trainers	VA 12512 VA 44909 (Non-Clinical) VA 44715 (Abridged Non-Clinical)	N/A
Facility Trainer Recertification Assessment (FTRA)		Once	Certified PMDB Trainers who wish to recertify	VA 13500	N/A

Appendix B

Evidence-Based Project Outline

BEHAVIORAL EMERGENCY CODE (CODE GREEN) PILOT PROGRAM OUTLINE

I. PURPOSE: To describe procedures and responsibilities in the management of behavioral emergencies within the hospital.

II. POLICY: To ensure a rapid, safe, and effective response to behavioral emergencies involving patients throughout the hospital by ensuring patient-centered care and effective emergency management by the least harmful and restrictive method.

Ill. DEFINITIONS:

A. Behavioral emergency: A threatening situation where a person presents an imminent danger of physical harm to himself, others, and/or the environment.

B. Lack of capacity due to a medical condition: Some patients may lack the capacity to make an informed decision to terminate care due to a medical condition such as encephalopathy, dementia, Alzheimer's, or traumatic brain injury. These patients do not meet the criteria for LPS involuntary detention, and decisions regarding whether to support their intention to leave treatment will be based on harm reduction/ injury prevention.

C. Code Green: The agreed-upon code symbolizes the need for a behavioral emergency team to respond to a specific location.

D. Inpatient care units include only the following: CCCU, S4 DOU, N4, S8, S10, L1, and M1.

E. Outpatient areas for the pilot program will consist of only the emergency department.

IV. PROCEDURE - (Inpatient and Related Areas):

A. Behavioral Code Team:

1. The employee observing a behavioral emergency with an inpatient will immediately activate a Behavioral Code Team by dialing extension 11111 on a VA desk phone. The emergency line operator will respond, "Are you reporting a code green or behavioral emergency?" If the answer is "yes," provide the operator with the building and room number. The operator will send out the

page to the Code Green team members with the location. Code Green team members then respond.

2. *A Behavioral Code Team should <u>never</u> be used in a situation involving a person armed with any weapon. When calling VA police or 911 to notify police of an armed individual, inform the operator that this emergency involves an individual with a weapon.*

3. Protection to Bystanders: In any disruptive situation posing a potential danger, patients and visitors at risk will be moved to a safer area.

4. Behavioral Code Team Arrival:

   a. <u>Administrative Hours:</u>   Behavioral Code Team
      1) L1 Nursing Staff
      2) M1 Nursing Staff
      3) Psychiatry MD (for assessment and treatment, not restraining)
      4) Social Worker
      5) VA Police

   b. <u>Non-Administrative Hours:</u> Behavioral Code Team
      1) L1 Nursing Staff
      2) M1 Nursing Staff
      3) Nursing Officer of the Day (NOD)
      4) Mental Health Nocturnist (for assessment and treatment, not restraining)
      5) VA Police

   c. The behavioral Code Team will be divided into a Primary Team and a Secondary Team.

      1) <u>The Primary Team</u> will conduct a brief assessment of the situation and develop a hierarchical restraint contingency plan based on principles learned in the training of prevention and management of disruptive behavior (PMDB)

      2) <u>The Secondary Team</u> will consist of unit staff/VAPD and assist with a contingency plan.

      3) <u>Team Roles</u>: Lead Nurse, Communicator/De-escalator, medication nurse, SBAR nurse, safety monitor.

5. Post-Incident Follow-Up:

a. The Veterans Affairs Employee Assistance Program (EAP) will be available to those employees involved in workplace violence.

b. After-incident assistance for patients is available through the Mental Health Clinic.

c. Visitors involved in such disturbances will receive emergency medical and/or psychiatric treatment in the ED if indicated by a clinician.

d. L1 and/or M1 Nurse Manager (NM) or designee will evaluate all Behavioral Code Team reports and provide follow-up debriefing with staff involved as needed.

e. The Director's Office will determine other follow-ups on an individual basis.

B. RESPONSIBILITIES:

1. Medical/Surgical Units: The inpatient and outpatient units will handle uncooperative and non-compliant inpatients when there is no threat of injury or bodily harm to the patient or staff in the judgment of the charge nurse or designee. It is expected that the unit staff will be able to articulate the specific nature of the behavioral emergency, or the patient's behavior will demonstrate the need for calling for a Behavioral Code Team and VAPD away from their respective areas/duties. For example, the team should *not* be called when a patient refuses to go to bed, has fallen on the floor, needs assistance to transfer to a wheelchair, does not want to cooperate with putting on hospital-issued pajamas, or when a voluntary patient refuses to take medication or wants to leave AMA. The behavioral Code Team *will* be called to assist with inpatient behavioral emergencies when the inpatient unit needs additional resources are required.

2. The Primary Behavioral Code Team is responsible for assessing the Behavioral Code Team situation and determining what actions are appropriate.
   They will provide verbal and/or physical restraint appropriate to the patient's needs. The primary team consists of 5 roles:
   1) Lead Nurse: Licensed individual who can delegate care, such as, but not limited to, charge nurse, registered nurse directly caring for Veteran, nursing supervisor, and nurse manager/assistant nurse manager
   2) Communicator/De-escalator: S/he serves as a line of communication for Veteran immediate needs. Responsible for building and manning rapport with Veterans. Communicator/De-escalator can be filled by an MD, RN, VAPD, and or support staff.
   3) The Situation, Background, Assessment, Recommendation (SBAR) nurse: Responsible for gathering information about the Veteran and organizing it in an SBAR format.
   4) Medication nurse: Know the medication available to the Veteran. Have the PRN medical ready to administer and/or work with the provider to write the appropriate orders.
   5) Safety Monitor: All 5 roles should also act as safety monitors while conducting their assigned roles. Safety monitor will ensure the restraints are on standby, aid in restraint and seclusion if needed, remove unsafe objects, and clear the hallway of bystanders.

4. <u>L1 or M1 Nursing Staff will:</u>

    1) Identify team members and conduct a team assessment

    2) Apply and/or direct application of restraints per Hospital Memoranda Behavioral Health Restraint and Seclusion Policy, Medical-Surgical Care Restraint Policy.

    3) Assist in the leadership of the Behavioral Code Team.

    4) Clearly signal to the police if they feel in danger.

    5) Conduct a "post-code" debriefing for team members or chosen designees.

    6) Complete the Behavioral Code Team Debriefing and attendance forms (see Attachment).

    7) Send the Behavioral Code Team Debriefing Form to the NM or designee of the Inpatient Psychiatric Unit.

5. <u>Nursing Officer of the Day (NOD):</u> Will respond during non-administrative hours and render support and assistance to the initiating unit and responders.

6. <u>Social Worker:</u> Will respond during administrative hours to provide additional coping skills, assistance, and access to available VA support systems.

7. The Secondary Team: It is the responsibility to support the functions of the Behavioral Code Team. Secondary team members would consist of unit staff and VAPD.

a. In the event that an assessment reveals additional staff is needed, the Secondary Team members will participate in additional roles at the direction of the Team Leader.

b. In the event that any member of the Primary Team becomes disabled, has physical limitations that prevent them from participating, or otherwise is ineffective in applying physical restraint, Secondary Team members must be ready to render immediate assistance.

c. Remain present until dismissed by the unit-affected charge nurse.

6. Charge Nurse or designee of the affected unit will:

a. Ensure that a full account of any behavioral emergency will be made immediately in CPRS under the Behavioral Code Team Note template. The note will be reviewed and countersigned by the charge nurse (if applicable) and the attending physician (if applicable).

b. Ensure that a Disruptive Behavior Reporting System report is completed for all patient-on- patient assaults, patient-on-staff assaults, patient self-inflicted injury, homicides, rape, suicide, and suicidal behavior.

c. Notify the patient's MD to obtain a psychiatric consult.

d. Ensure a Joint Patient Safety Reporting (JPSR) is completed with required details.

e. Ensure appropriate staff remains available to assist the Primary, Secondary, and Police if needed until dismissed.

7. VA Police will:

a. Function as Secondary Team members for INPATIENT BEHAVIORAL CODE TEAM incidents and assist with the assessment and restraint process as needed.

b. Take the lead in the incident when it is apparent that a weapon is or becomes involved.

c. VA Police hold the authority to intervene if the office at the scene deems the situation to be a police matter.

d. The senior or responsible patient care staff member at a scene should always **clearly** signal to the police if they feel in danger. Members of the treatment team should remain available to assist the police in pursuing appropriate restraint courses or attempts at voluntary submission. When control of the patient has been established, the police must clearly indicate the return of patient responsibility to the patient care staff and the termination of their involvement.

e. Assume full responsibility for the management of the code if it is assessed that the code is criminal in nature.

f. Act as liaisons if it is necessary to involve local police agencies.

g. Send Police Uniform Offense Reports to Safety Officer immediately via e-mail and routed to the Disruptive Behavior Committee (DBC) to assist in the incident review.

8. The Psychiatric MD will respond during administrative hours, and the Mental Health Nocturnist will respond during non-administrator hours. Whey will respond to all Behavioral Code Team calls to provide medical/psychiatric support. They will not have a direct role in the restraint process.

9. <u>MH NM or designee will:</u>

   a. Present the data/reports to the Chief of Police or designee and members of the DBC monthly or more frequently if needed.

   b. Report to the Quality Council annually.

V. <u>PROCEDURES</u> (Outpatient and Related Areas):

   A. POLICE RESPONSE:

   1. Outpatient behavioral emergencies will be activated by a duress alarm activated by pressing both control keys of your keyboard or by dialing 911 and requesting police assistance. NOTE: Please notify POLICE of behavioral emergencies involving outpatients and/or visitors. *A BEHAVIORAL CODE TEAM is to be utilized for inpatients only.*

   2. Protection to bystanders. In any disruptive situation posing potential danger, patients and visitors at risk will be moved to a safer area.

   3. Police will immediately be involved in resolving the behavioral emergency.

   4. If the police determine that a Behavioral Code Team should be called, they will direct staff to do so.

   5. Post-incident follow-up:

      a. <u>The Veterans Affairs Employee Assistance Program (EAP)</u> will be available to those employees involved in workplace violence incidents.

      b. After-incident assistance for patients is available through the Mental Health Clinic.

      c. Visitors involved in such disturbances will receive emergency medical and/or psychiatric treatment in the ED.

      d. The Director's Office will determine other follow-ups on an individual basis.

B. RESPONSIBILITIES:

1. VA Police will respond to all behavioral emergencies and direct all outpatient behavioral emergencies.

2. VA clinical staff may provide VA Police Service with individually-identifiable information regarding a serious or imminent threat to the health or safety of an individual (e.g., employee) or the public (e.g., bomb threat) as long as the VA Police are reasonably able to prevent or lessen the threat.

3. VA Police may initiate a Behavioral Code Team response if the emergency is deemed to be of a clinical nature or if they require additional staff present for effective patient-centered care.

4. Patient care staff at the scene should always remain available to assist the police in pursuing appropriate courses of restraint or attempts at voluntary submission.

Appendix C

John Hopkins Evidence-Based Practice Model for Nursing and Healthcare Professionals

Evidence Levels	Quality Ratings
Level I Experimental study, randomized controlled trial (RCT) Explanatory mixed method design that includes only a level I quaNtitative study Systematic review of RCTs, with or without meta-analysis	**QuaNtitative Studies** **A** **High quality**: Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence. **B** **Good quality**: Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence. **C** **Low quality or major flaws**: Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn.
Level II Quasi-experimental study Explanatory mixed method design that includes only a level II quaNtitative study Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis	**QuaLitative Studies** No commonly agreed-on principles exist for judging the quality of quaLitative studies. It is a subjective process based on the extent to which study data contributes to synthesis and how much information is known about the researchers' efforts to meet the appraisal criteria. *For meta-synthesis, there is preliminary agreement that quality assessments of individual studies should be made before synthesis to screen out poor-quality studies[1].*
Level III Nonexperimental study Systematic review of a combination of RCTs, quasi-experimental and nonexperimental studies, or nonexperimental studies only, with or without meta-analysis Exploratory, convergent, or multiphasic mixed methods studies Explanatory mixed method design that includes only a level III quaNtitative study QuaLitative study Meta-synthesis	**A/B** **High/Good quality** is used for single studies and meta-syntheses[2]. The report discusses efforts to enhance or evaluate the quality of the data and the overall inquiry in sufficient detail; and it describes the specific techniques used to enhance the quality of the inquiry. Evidence of some or all of the following is found in the report: • Transparency: Describes how information was documented to justify decisions, how data were reviewed by others, and how themes and categories were formulated. • Diligence: Reads and rereads data to check interpretations; seeks opportunity to find multiple sources to corroborate evidence. • Verification: The process of checking, confirming, and ensuring methodologic coherence. • Self-reflection and scrutiny: Being continuously aware of how a researcher's experiences, background, or prejudices might shape and bias analysis and interpretations. • Participant-driven inquiry: Participants shape the scope and breadth of questions; analysis and interpretation give voice to those who participated. • Insightful interpretation: Data and knowledge are linked in meaningful ways to relevant literature. **C** **Low quality** studies contribute little to the overall review of findings and have few, if any, of the features listed for high/good quality.

Evidence Levels	Quality Ratings
Level IV Opinion of respected authorities and/or nationally recognized expert committees or consensus panels based on scientific evidence Includes: • Clinical practice guidelines • Consensus panels/position statements	**A** <u>**High quality:**</u> Material officially sponsored by a professional, public, or private organization or a government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise clearly evident; developed or revised within the past five years **B** <u>**Good quality:**</u> Material officially sponsored by a professional, public, or private organization or a government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise clearly evident; developed or revised within the past five years **C** <u>**Low quality or major flaws:**</u> Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the past five years
Level V Based on experiential and nonresearch evidence Includes: • Integrative reviews • Literature reviews • Quality improvement, program, or financial evaluation • Case reports • Opinion of nationally recognized expert(s) based on experiential evidence	**Organizational Experience (quality improvement, program or financial evaluation)** **A** <u>**High quality**</u>: Clear aims and objectives; consistent results across multiple settings; formal quality improvement, financial, or program evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence **B** <u>**Good quality**</u>: Clear aims and objectives; consistent results in a single setting; formal quality improvement, financial, or program evaluation methods used; reasonably consistent recommendations with some reference to scientific evidence **C** <u>**Low quality or major flaws**</u>: Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement, financial, or program evaluation methods; recommendations cannot be made **Integrative Review, Literature Review, Expert Opinion, Case Report, Community Standard, Clinician Experience, Consumer Preference** **A** <u>**High quality**</u>: Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader(s) in the field **B** <u>**Good quality**</u>: Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions **C** <u>**Low quality or major flaws**</u>: Expertise is not discernable or is dubious; conclusions cannot be drawn

Appendix D

Summary of Primary Research Evidence

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison (Definitions should include any specific research tools used along with reliability & validity)	Theoretical Foundation	Outcome Definition	Usefulness Results Key Findings
Digby, R., Bushell, H., & Bucknall, T. K. (2020). Implementing a psychiatric behaviors of concern emergency team in an acute inpatient psychiatry unit: Staff perspectives. *International Journal of Mental Health Nursing*, 29(5), 888–898. https://doi.org/10.1111/inm.12723	**Design** Qualitative Research Design **Level** III **Grade** B	**Sample** Healthcare Employees of a two adult acute psychiatry. **Sample size** 1.Managerial (n = 3). 2. Shift leaders/allied health (n=7). 3. Nursing (n=12) 4. Medical group (n=2).	**Intervention** interview guide created by researchers to discuss feelings about psychiatric behaviors of concern (Psy-BOC) response team. **Comparison** Compared pre and post-implementation of Psy-BOC.	Theoretical framework for this study was not identified.	4 Main themes arose from the interview. -ID Deterioration Pt -Responding to behaviors -Staff Reaction -Barriers to Psy-BOC	**Implication for Practice** Changing practice to a model of minimal restraint and seclusion requires a well-considered and supportive roll-out to enable frontline staff to change practice successfully. Senior staff must provide strong leadership, encourage the use of alternative solutions, and model best practices in a nonpunitive and supportive setting. Ensuring that the ward environment is conducive to the

						care required has a considerable bearing on the ability of staff to comply with this new model
Godfrey, J. L., McGill, A. C., Jones, N., Oxley, S. L., & Carr, R. M. (2014). Anatomy of a transformation: A systematic effort to reduce mechanical restraints at a state psychiatric hospital. *Psychiatric Services*, *65*(10), 1277–1280. https://doi.org/10.1176/appi.ps.201300247	**Design** Quantitative Pre/Post Intervention Study **Level** III **Grade** A	**Sample** -State psych hospital in North Carolina -Primary population individuals with schizophrenia-spectrum disorders, mood disorders, and substance abuse. **Sample size** -140-bed acute adult unit (AAU) -76-bed community transition unit (CTU). -Adults age 18-64. -All patients were admitted from September 1, 2009, to July 31, 2012.	**Intervention** Two main Strategies to reduce mechanical restraints. 1. Training staff in de-escalation techniques and forming a response team. 2. Introduce formal policy changes that require additional upper-management approval **Comparison** One-way Multivariate analysis of variance (MONOVA) was conducted for each unit.	Theoretical framework for this study was not identified.	Significant reduction in mechanical restraints. AAU: Mechanical Restraints: Base: 0.57 Phase 1: 0.24 Phase 2: 0.49 CTU: Mechanical Restraints: Base: 0.09 Phase 1: 0.02 Phase 2: 0.	The response team and policy phase of the study showed a significant reduction in the use of mechanical restraints in both units, AAU and CTU.

	Design	Sample	Intervention	Theoretical framework for this study was not identified.	BRS calls: ---Men: 68.1%	Regular activation of the BRS since it was implemented in 2015 suggests a perceived utility by the staff on a range of medical and surgical services. Further, the length and frequency of the calls suggest that a BRS is not a significant burden on hospital resources or staff time. For one-third of calls, the BRS used de-escalation techniques without needing to resort to restraint
Moore, C., Damari, N., Liles, E., & Bramson, B. (2019). Who you gonna call? Outcomes of a team-based approach to respond to disruptive behavioral issues in hospitalized patients. *The Joint Commission Journal on Quality and Patient Safety*, *45*(11), 781–785. https://doi.org/10.1016/j.jcjq.2019.08.006	Quantitative Retrospective Descriptive Study **Level** II **Grade** A	Tertiary care academic medical center. **Sample size** -All patients were admitted from July 1, 2016, through June 30, 2017. -191 adult patients with 271 Behavioral response system (BRS) calls.	-Manually reviewed electronic medical records (EMR) and collected patient demographic information, hospital service, diagnosis codes, substance abuse history, psychiatric history, and description of BRS. **Comparison** Descriptive statistics were calculated using the Student's t-test for continuous variables and the chi-square test for dichotomous variables. Logistic regression was used to evaluate the association between demographic and clinical characteristics.		-53.9% white -31.4% black -14.7% other -6%Hispanic -Average age 49.9. -BRS call: 0-9 per day. -Median length of call: 30 minutes (range 5-90 minutes). -45% verbal abuse and threatening to leave the hospital. -5.2% of BRS activated due to verbal abuse alone. -4.4% staff injury. -4.1% patient injury. -54% used chemical restraints. -28.8% mechanical restraints. -17.7% were placed in manual holds. -65 and older/dementia/ Delirium dx was a sig predictor of chemical and mechanical restraints.	

Pinkhasov, A., Hallo, C., Avishai, A., Akerman, M., & Brand, D. A. (2020). Toward prevention of behavioral emergencies in a general hospital insights from a one-year series. *General Hospital Psychiatry*, *66*, 54–58. https://doi.org/10.1016/j.genhosppsych.2020.06.008	**Design** Cross-sectional study **Level** II **Grade** A **Sample size** 83 patients between January 1 and December 31, 2017, at a 595-bed hospital.	**Sample** New York metropolitan area teaching hospital without a specialized psychiatric unit.	**Intervention** Cross-sectional study examined a consecutive series of behavioral emergencies that occurred at a 595-bed teaching hospital without a psychiatric unit. **Comparison** -Univariate analyses compared study and control patients using chi-square or Fisher's exact test for categorical data. -Two sample t-test or Mann-Whitney test for continuous data -P-value less than a Bonferroni-corrected threshold (p < 0.01) is statistically significant	Theoretical framework for this study was not identified.	Control group: (Pt who did not trigger an RRT): n=22,849. RRT for Behavior: n=83. -Males are twice as likely to RRT (p<0.0001). -Most frequently principle dx in the study group: substance abuse, disorders of the digestive system, and cerebrovascular disease -4 out of 5 patients (68/83) presented with psychiatric comorbidities -RRT was successful in 22.9% (19/83) verbal de-escalation. -RRT team used mechanical restraints 10.8% (9/83), the remainder received chemical restraints. -1 and 4 pts require direct Obs.	Inclusion of behavioral health expertise in a hospital's rapid response team has the potential to decrease the need for restraints by increasing the emphasis on verbal de-escalation and appropriate psychopharmacologic management. Finally, structured documentation of behavioral emergencies in patients' medical records would aid further research to identify triggers and circumstances surrounding these incidents, potentially leading to more effective prevention.

	Design Prospective Study **Level** II **Grade** A	**Sample** Pennsylvania state hospitals system.	**Intervention** Hospital integrated: -Response teams. -Staff training. -Data transparency. -Treatment malls. -Leadership. -Advocacy.	Theoretical framework for this study was not identified.	Mechanical restraints significantly declined from: 2001: .37 episodes of mechanical restraints per 1,000 days (N=324). 2010: .08 episodes of mechanical restraints per 1,000 days. (N=39, P<0.018.).	Behavioral code team intervention was cited for contributing to the decrease in mechanical restraints by: -Ensuring compliance with hospital policy.
Smith, G. M., Ashbridge, D. M., Davis, R. H., & Steinmetz, W. (2015). Correlation between reduction of seclusion and restraint and assaults by patients in Pennsylvania's state hospitals. *Psychiatric Services*, *66*(3), 303–309. https://doi.org/10.1176/appi.ps.201400185						-ID conflicts that lead to restraints. -Providing a therapeutic response to a crisis. -Provided the most experienced staff at the scene of a crisis.
		Sample size -1,801 patients, ages 18 and older -12,900 Events. -January 1, 2001, to December 31 2010.	**Comparison** -Compared 14,430 containment procedures (mechanical restraints, seclusion, physical restraint) were used during 12,900 events. -SPSS version 22 statistical software was used for linear regression analysis. -Statistical significance P<.05 -Pearson correlation coefficient was used to analyze the relationship between decreased restraints and assaults		Patient time spent in mechanical restraints decreased significantly: 2001: 0.52 hours per 1,000 days (N=448). 2010: 0.07 hours per 1,000 days (N=34, P<.05). Patient-to-patient assault showed a slight decline. No change in patient to staff assault.	

Snorrason, J., & Biering, P. (2018). The attributes of successful de-escalation and restraint teams. *International Journal of Mental Health Nursing*, *27*(6), 1842–1850. https://doi.org/10.1111/inm.12493	**Design** Qualitative, Structured Individual Interview **Level** III **Grade** B	**Sample** Icelandic State and University Hospitals **Sample size** -12-De-escalate and restrain patients with aggression (D-E-R) team members. -8 males -4 females -Age- 25-48 -mean age: 35.3.	**Intervention** Two stages of data interpretation. 1. Interview phase: Clarify the participant's understanding of the study text. 2. When interpreting the text, the interview would engage in a dialogue **Comparison** Van Manen's (1990) analysis, based on the epistemological assumption that is congruent with hermeneutic tradition, was used in thematic analysis to transfer their understanding into concepts.	Gadamer's philosophical hermeneutics (1960/1998) and Ricoeur's (1981) hermeneutic methodology. The framework goal of understanding was an agreement between the investigator and the subject. The investigator collected data but also discussed the research with the subjects.	Central theme emerging from the interviews was a concept of a safe team. -Ensuring the safety of a team and each team member as a prerequisite for successful teamwork in managing an aggressive patient.	The study stress that when staff fail to calm down a patient with aggression, it can be vital for the safety of the patient and staff to have access to a well-trained D-E-R team to de-escalate or restrain the patient. Therefore, it is of great importance to understand the factors that enhance the D-E-R team. These skills are necessary for successful de-escalation and for avoiding mechanical restraint.
Wong, A., 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), 859–865.	**Design** Quantitative, Pre-Post Design **Level** III **Grade**	**Sample** ED Staff Members **Sample size** -162 ED staff members	**Intervention** Multi-modality, team-based approach to create a novel simulation-enhanced safety	David Kolb's experiential learning theory	Constructs for internal/biomedical factors, external/staff factors, and situational/interactional perspectives on patient aggression significantly improved	Staff participants gradually generated a list of quality improvement initiatives as the weeks went by, many of which were successfully implemented,

| | A | completed the course. -106 completed the survey | curriculum targeting staff attitude towards patient aggression. The study implemented a structured team approach that promotes interprofessional collaboration to manage aggressive patients

Comparison
Survey-based design comparing pre-and post-intervention responses via a paired Student t-test to assess the changes in staff attitudes. | | (p<0.0001, p<0.002, p<0.0001 respectively). | including the creation of an ED-based interprofessional crisis management alert and response protocol. |

Legend: acute adult unit (AAU), behavioral response system (BRS), community transition unit (CTU), de-escalate and restrain patients with aggression (D-E-R), emergency department (ED), electronic medical records (EMR), rapid response team (RRT), psychiatric behaviors of concern (Psy-BOC),

Appendix E

Strengths Weakness Opportunities and Threats Analysis

Internal Forces (Project)	External Forces (Organization or Environment)
Strengths (Internal) • VA Long Beach nursing leadership support. • The Joint Commission Support. • International Association of Hospital Security and Safety (IAHSS) support. • Quality, Safety, & Value department support. • Exiting committees and programs dedicated to workplace violence prevention.	**Opportunities (External)** • The national network of other VA hospitals that have implemented behavioral code team. • Decreased possibility of sentinel events. • Employee and patient safety. • Patient-centered care.
Weaknesses (Internal) • Inconvenient hospital layout. • Lack of standard protocols. • Access to nurses and other departments for training.	**Threats (External)** • Staff turnover. • Unplanned leave. • COVID-19 Surge. • Hospital is losing interest in the proposal.

Appendix F

Project Schedule

Activity	NUR7801								NUR7802								NUR7803							
	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15	Week 1	Week 3	Week 5	Week 7	Week 9	Week 11	Week 13	Week 15
Meet with preceptor	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Prepare project project	█	█	█	█	█	█	█																	
Review IRB project approval process									█	█	█													
Submit the project									█	█	█													
Generate awareness	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Outline with DBC input									█	█	█	█												
Submit to USA project approval and facility IRB.										█	█													
Receive facility Outline approval.									█	█														
Project Schedule shared with stakeholders											█													
Receive facility policy and outline approval											█													
Begin implementation of the project												█	█	█	█	█								
Ensure staff have PMDB training									█	█	█													
Audit debriefing sheet data and provide feedback to stakeholders												█	█	█	█	█								
Data collection												█	█	█	█	█	█	█	█					
Evaluation																				█	█	█		
Project closure																							█	█

Appendix G

Data Collection Tool

Number Restraints Pre/Post Intervention

Unit	Pre-data Oct-21	Pre-data Nov-21	Post-data Dec-21	Post-data Jan-22
CCCU	3	14	3	8
DOU	6	5	2	16
L1	3	3	2	1
M1	0	0	0	0
N4	23	16	51	17
S10	27	11	11	7
S8	2	3	10	7
ER	7	10	5	3
Unknown	26	3	2	1
Total	97	65	86	60

Appendix H

Behavioral Code Team Form

1. The call for the behavioral code team was justified because:
___ **the patient's behavior was out of control**
___ **the patient was attempting to harm him/herself**
___ **the patient was attempting to harm someone else**
___ **the patient was attempting to or had succeeded in interfering with essential medical treatment**
___ **NA (see comments #2)**

2.   Call for the behavioral code team was not justified because:

_____

3. This intervention was successful in that:
____ **the patient's behavior was addressed in the least restrictive environment/ manner**
____ **recommendations of the behavioral code team were communicated to unit staff**
____ **the patient is now safe and in control**
____ **other (describe)_____**
____ **NA: Intervention not needed; situation resolved prior to team arrival.**

4. Event Outcome:
___**Verbal redirection**
___**Mechanical restraints**
___**PRN medication**
___**Seclusion room**
___**Mechanical restraints, PRN medication, seclusion room**
___**other (describe)_____**

5.   What, if anything, could have been done differently to achieve better results?
___ **Nothing, this intervention went well.**
___ **The intervention might have had more satisfactory results if (describe)_____**
_____
_____

6. Is there any recommendation/ action/ follow-up needed?
___**No**
___**Yes (describe)_____**

__ **7. Staff or patient injury Yes (describe)**

Debriefing completed by: _____Date: _____
                                                Team Leader
**Reviewed by Project Manager:_____Date: _____**

Appendix I

Behavioral Code Team Responses

Date	Unit	Intervention	Injury Pt/Staff
12.15.22	Emergency Department	Resolved prior	No
12.21.21	Emergency department	Restraints	No
12.23.21	Psych Department (L1)	Verbal Redirection	No
12.23.21	Psych Department (L1)	Verbal Redirection	No
01.05.22	General Medicine (S10)	Verbal Redirection	No
01.06.22	General Medicine (S8)	Verbal Redirection	No
01.10.22	General Medicine (S10)	Restraints	No
01.12.22	General Medicine (S10)	Resolved prior	No
01.14.22	Definitive Observation Unit	Resolved prior	No
01.20.22	General Medicine (4N)	PRN Medication	No
01.24.22	General Medicine (S8)	PRN Medication	No
01.31.22	Emergency Department	Resolved prior	No

Appendix J

Mean Restraint Usage for October 2021 (Pre-Intervention) and January 2022 (Post-Intervention)
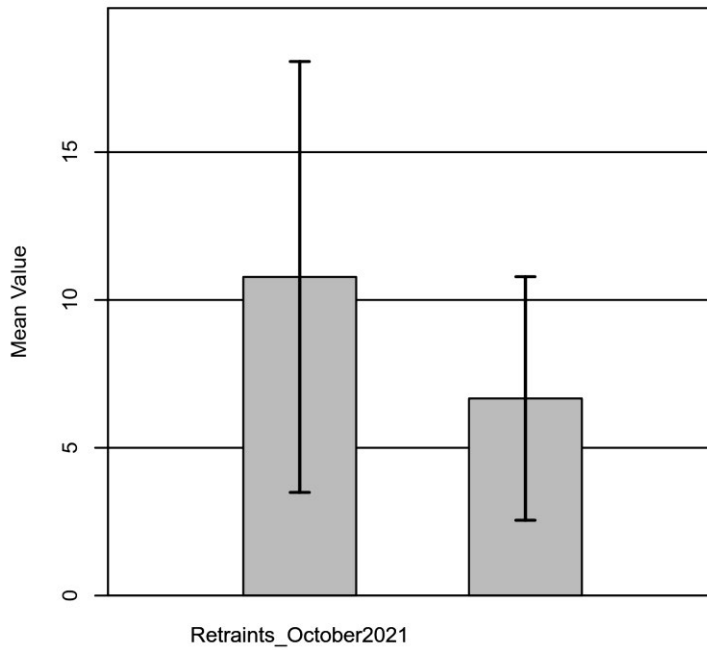
Two-Tailed Paired Samples t-Test for the Difference Between Restraints October 2021 and Restraints January 2022

Restraints October 2021		Restraints January 2022				
M	SD	M	SD	t	p	d
10.78	11.16	6.67	6.30	1.06	.319	0.35

Appendix K

Behavioral Code Team Responses with Interventions

Frequency Table for Nominal Variables

Variable	*n*	*%*
Unit: # of Behavioral Codes		
ER	3	25.00
L1	2	16.67
S10	3	25.00
S8	2	16.67
DOU	1	8.33
4N	1	8.33
Missing	0	0.00
Intervention		
Resolved prior	4	33.33
Restraints	2	16.67
Verbal Redirection	4	33.33
PRN Medication	2	16.67
Missing	0	0.00
Injury Pt/Staff		
No	12	100.00
Yes	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.