# Team-based approach to behavioral health emergencies

## Pre-defined roles and training can help address disruptive client incidents.

By Christopher James Bonine, BSN, RN-BC

**BEHAVIORAL HEALTH EMERGENCIES** are never planned and seldom go as expected, but studies suggest that as few as 20% to 40% of hospitals have a formal plan to address combative clients. With nearly half of healthcare staff reportedly experiencing violence in the workplace, organized mechanisms to sensitively address behavioral health emergencies have never been more relevant. With the right standard operating procedure, staff can address a behavioral crisis safely and therapeutically. REACT (**R**apport, **E**scort, **A**ntipsychotics/anxiolytics, **C**ommunicate, **T**imes) is an evidence-based protocol, which can be implemented by four or five staff members, that consists of a versatile mechanism for responding to behavioral health emergencies.

Proactive attempts to foster client satisfaction and rapport are always preferable to allowing an incident to escalate to a behavioral health emergency, but sometimes verbal de-escalation is fruitless and an active outburst must be addressed. Consider the following example:

*A client well known to you and your staff is admitted to your hospital unit. Although the client typically is polite but aloof, his history and disposition today suggest amphetamine-induced psychosis. He throws his meal tray against the wall and begins to furiously disassemble his room's call light apparatus while shouting incomprehensibly at staff. As the damage to facility property begins to mount, and the client turns his aggression toward staff, you begin to fear for the safety of the client, other clients, visitors, and staff.*

What do you do in this situation? You need to REACT.

### Rapport

First, assign the staff member who has the best *rapport* with the client as a one-to-one caregiver. Frequently, this is the staff member who's known the client the longest. This step is important because even in a confrontational situation requiring the involuntary administration of antipsychotics, it's important to never lose sight of the fact that the disruptor is a client in urgent need of therapeutic care, not an adversary. The caregiver designated for this role will remain with the client, within eyesight and ideally—safety permitting—within arm's reach. This proximity provides one-to-one observation throughout the disruption to limit harm and serves as a foothold for returning to a therapeutic experience when the incident ends. Perhaps more importantly, this staff assignment provides a backdoor to resolve the crisis—while other staff members are preparing more extreme interventions, the caregiver can attempt rapport-based methods (for example, active listening,

guided imagery, therapeutic silence, and redirection) to de-escalate the client.

## Escort

To limit collateral damage and monitor other at-risk clients, assign a staff member with the situational awareness necessary to conduct observational safety rounds to separate other clients and visitors from the agitated client. This staff member will *escort* visitors from the unit and closely monitor other emotionally unstable clients. Outbursts of this kind, especially in acute psychiatric settings, create opportunities for disruptions by others, suicide attempts, and other harmful incidents. In addition to ushering visitors off of the unit and separating uninvolved clients from the situation, this staff member must maintain an uninterrupted observation rounds schedule.

Second only to providing eyes-on observation of the agitated client, the flow of people is critical. Disruptive events frequently draw the attention of everyone on the unit, and this attention does little to de-escalate an agitated client.

## Antipsychotics/anxiolytics

Prepare *antipsychotics/anxiolytics* according to existing schedules, as needed, or standing orders. These medications—frequently administered intramuscularly to ensure a faster, more reliable mechanism of action—and supplies for cleaning and covering the injection site should be on hand and ready to use when needed. The sooner the client is stabilized, the sooner the client and milieu can resume their therapeutic work.

Prepare for medication orders to change as the situation develops. For example, if the caregiver's efforts to de-escalate the client are productive, the provider may choose to switch to oral medications. This will require securing the client's agreement for the change and reminding staff to ensure the medications aren't secreted in the client's mouth. These small compromises can help change the tone of an encounter.

## Communicate

As medications are being prepared, have another staff member communicate with the provider to procure orders and the course of treatment, as well as liaise with security, the nursing supervisor, and other key personnel. This is a natural role for the charge nurse because of the critical thinking and communication skills required.

## Times

Assign a unit clerk or other staff member to document interventions and the *times* they were implemented, especially if restraints are indicated. During an ongoing behavioral emergency, safety of the disruptive client and liability are important considerations. Documentation is critical, and it's easier to accomplish accurately as events occur rather than trying to reconstruct an encounter from call logs, medication administration times, and memory.

## Remove uncertainty

Response to behavioral health emergencies will vary based on unit and facility standard operating procedures, but when the REACT elements are implemented, risk to clients and staff and liability considerations are addressed. As with any team effort, staff can benefit from rehearsing their roles before an emergency occurs. A well-rehearsed protocol like REACT can remove the uncertainty from these encounters, allowing staff to maximize the impact of their expertise and minimize harm. AN

**Christopher James Bonine is an assistant nurse manager at the Chillicothe VA Medical Center in Chillicothe, Ohio.**

### References

Aremu B, Hill PD, McNeal JM, Petersen MA, Swanberg D, Delaney KR. Implementation of trauma-informed care and brief solution-focused therapy: A quality improvement project aimed at increasing engagement on an inpatient psychiatric unit. *J Psychosoc Nurs Ment Health Serv.* 2018;56(8):16-22.

Gottlieb M, Long B, Koyfman A. Approach to the agitated emergency department patient. *J Emerg Med.* 2018; 54(4):447-57.

Jury A, Lai J, Tuason C, et al. People who experience seclusion in adult mental health inpatient services: An examination of health of the nation outcome scales scores. *Int J Ment Health Nurs.* 2019;28(1):199-208.

Wood VJ, Vindrola-Padros C, Swart N, et al. One to one specialling and sitters in acute care hospitals: A scoping review. *Int J Nurs Stud.* 2018;84:61-77.

Yap CYL, Knott JC, Kong DCM, Gerdtz M, Stewart K, Taylor DM. Don't label me: A qualitative study of patients' perceptions and experiences of sedation during behavioral emergencies in the emergency department. *Acad Emerg Med.* 2017;24(8):957-67.

Zeller SL, Citrome L. Managing agitation associated with schizophrenia and bipolar disorder in the emergency setting. *West J Emerg Med.* 2016;17(2):165-72.