Resilience Redefined

Behavioural Escalation Support Team (BEST)

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Workplace Violence & Aggression

Workplace Violence and Aggression is "when a person is abused, threatened or assaulted at the workplace or while they are working" (SafeWork Australia, 2024)

On average 13.5% of health workers have suffered physical violence at some point in their career (Rosenthal et al., 2018)

73-98% of health workers have experienced verbal aggression (Cabilan & Johnston, 2019)

The minimum estimated cost of workplace violence and aggression is estimated at $30 billion a year in Australia (Ballard & Bozin, 2023)

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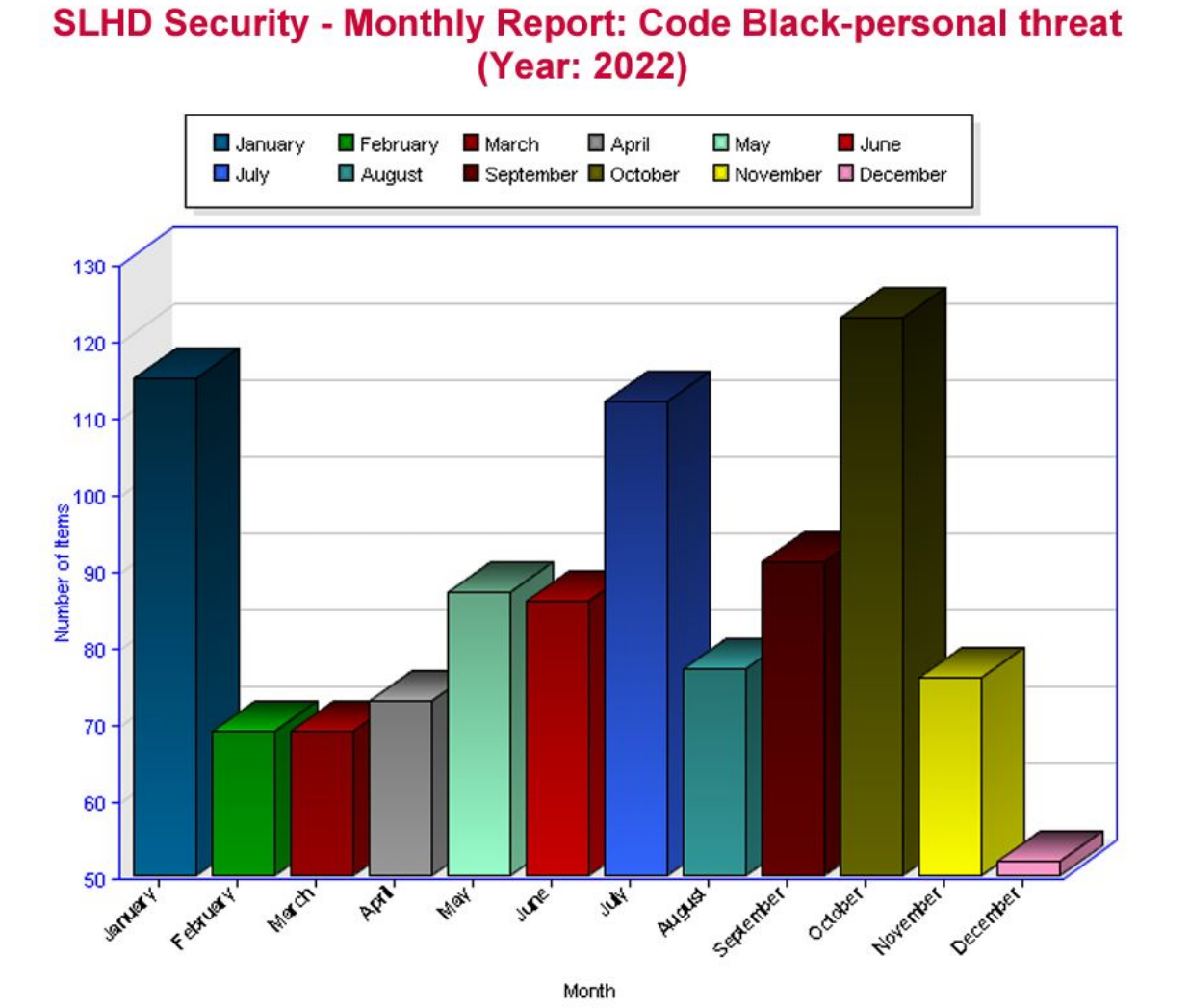
Behavioural Disturbance

Behaviour that puts the patient or others at immediate risk of serious harm and may include threatening or aggressive behaviour, extreme distress, and serious self-harm which could cause major injury or death.
(NSW Health, 2015)

2022 SLHD Data



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What is the Behavioural Escalation Support Team?

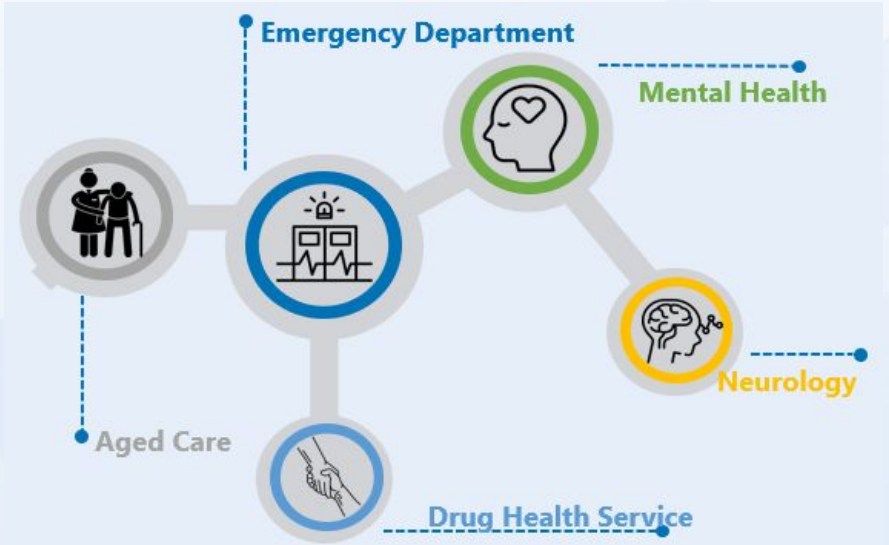
A clinical team designed to role model, support and empower staff in the care and best practice management of patients at risk of, or experiencing a behavioural disturbance.

Aim: To build confidence and capability to identify, escalate and manage patients with acute behavioural disturbance

Scope: Royal Prince Alfred Hospital, Acute inpatient departments

Hours of operation: Mon – Sun, 0700 - 1945

The Team: BEST Coordinator / Nurse Manager
BEST Clinicians
- Registered Nurses
- Diversional Therapist



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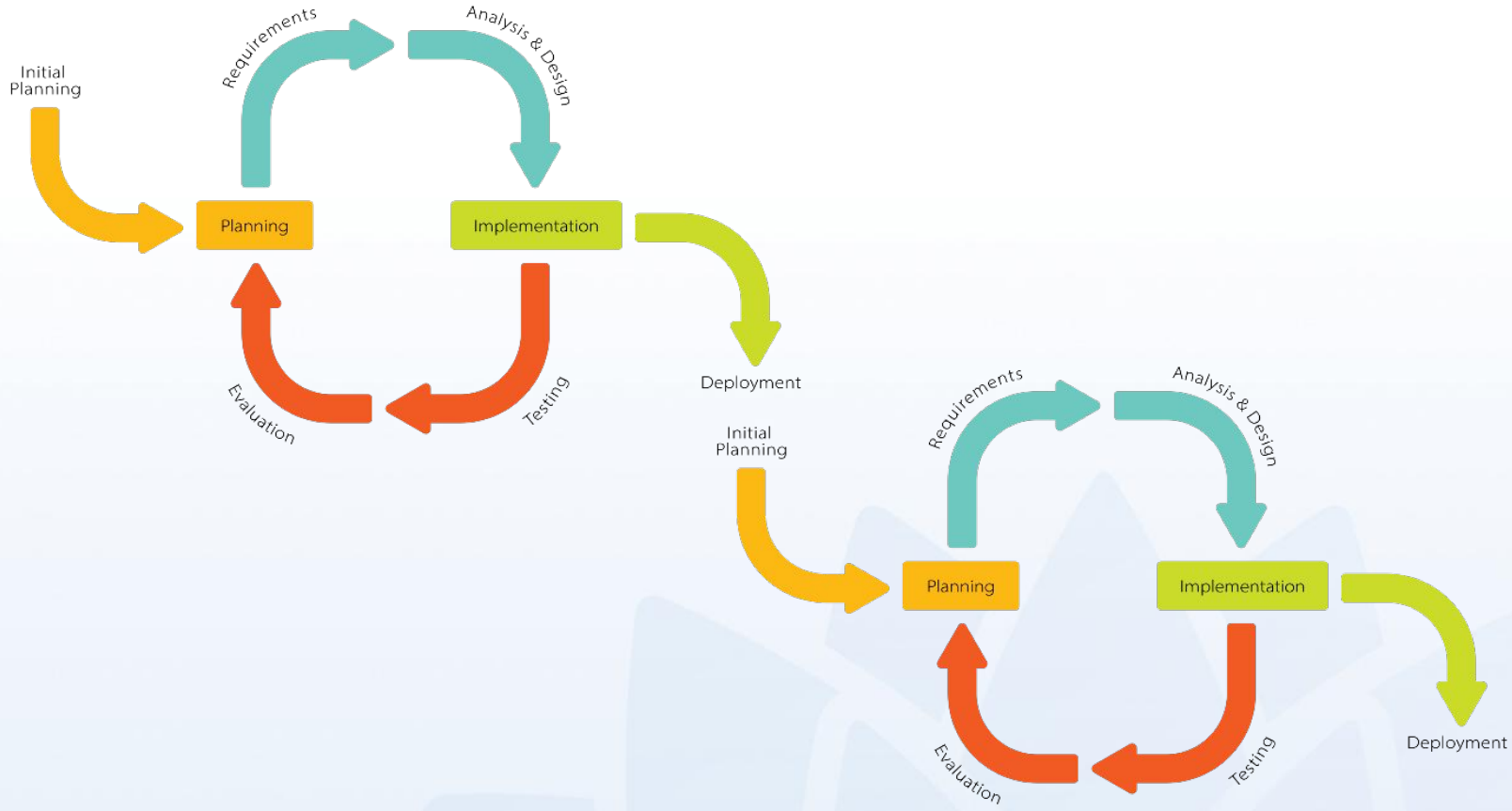
Implementation

- Iterative and incremental methodology
- Implementation commenced 12th November 2022
- Four stages of implementation
- Implementation complete 1st January 2024

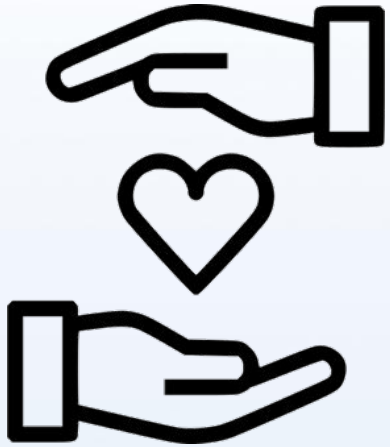


BEST Aims & Principles

BEST Aims

To make a positive contribution to healthcare service provision in RPA by:

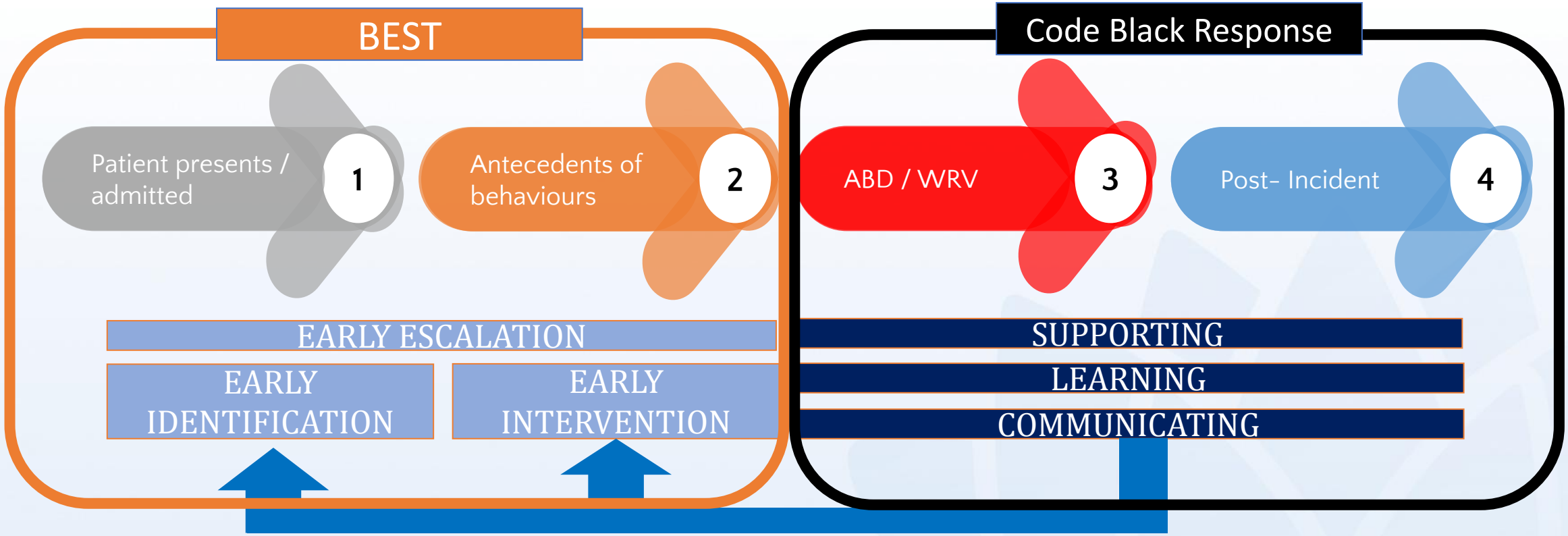
- Empowering clinicians
- Support patients and their families/carers
- Raising awareness of behavioural disturbance
- Increase understanding of available resources
- Develop Skills
- Improve Communication



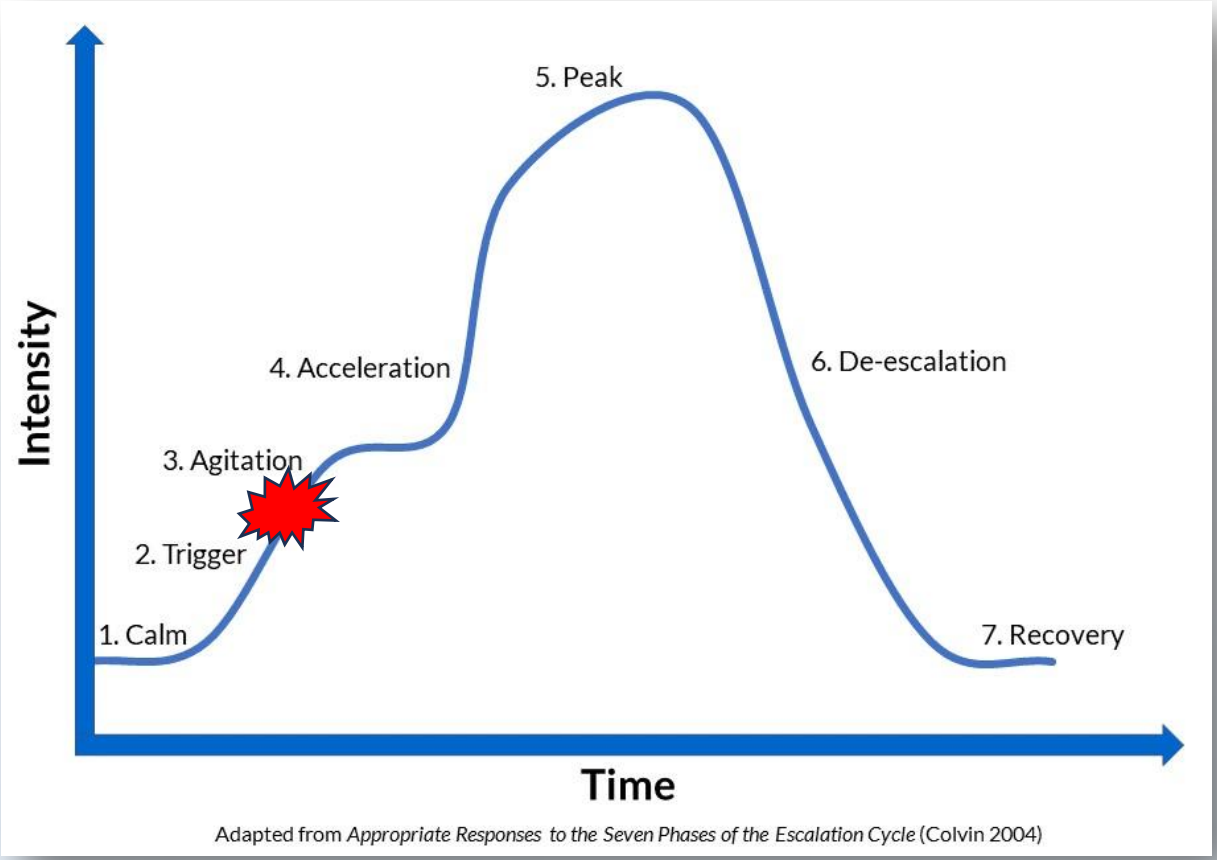
BEST principles

- Trauma informed care
- Patient centred care
- Least restrictive care

A typical behavioural escalation



Common Signs of Behavioural Disturbance



Adapted from *Appropriate Responses to the Seven Phases of the Escalation Cycle* (Colvin 2004)

Common signs:

- Raised voice
- Prolonged eye contact
- Clenched fists
- Glaring
- Pacing
- Withdrawal
- Standing tall
- Invasion of personal space
- Demanding behaviour
- Expression of anxiety beyond baseline

- Swearing
- Threatening remarks
- Other disinhibited behaviours

Referral pathway

- Urgent BEST call – For patients imminently escalating who are not yet a personal threat to self or others
- Pro-active referral – For patients who meet any one of the referral criteria below.

- Patients with a known history of behavioural disturbance
- Patients with an active aggression alert
- Patients with recent code black events
- Patients scoring > 1 on the 24-hour Behaviour Monitoring Tool

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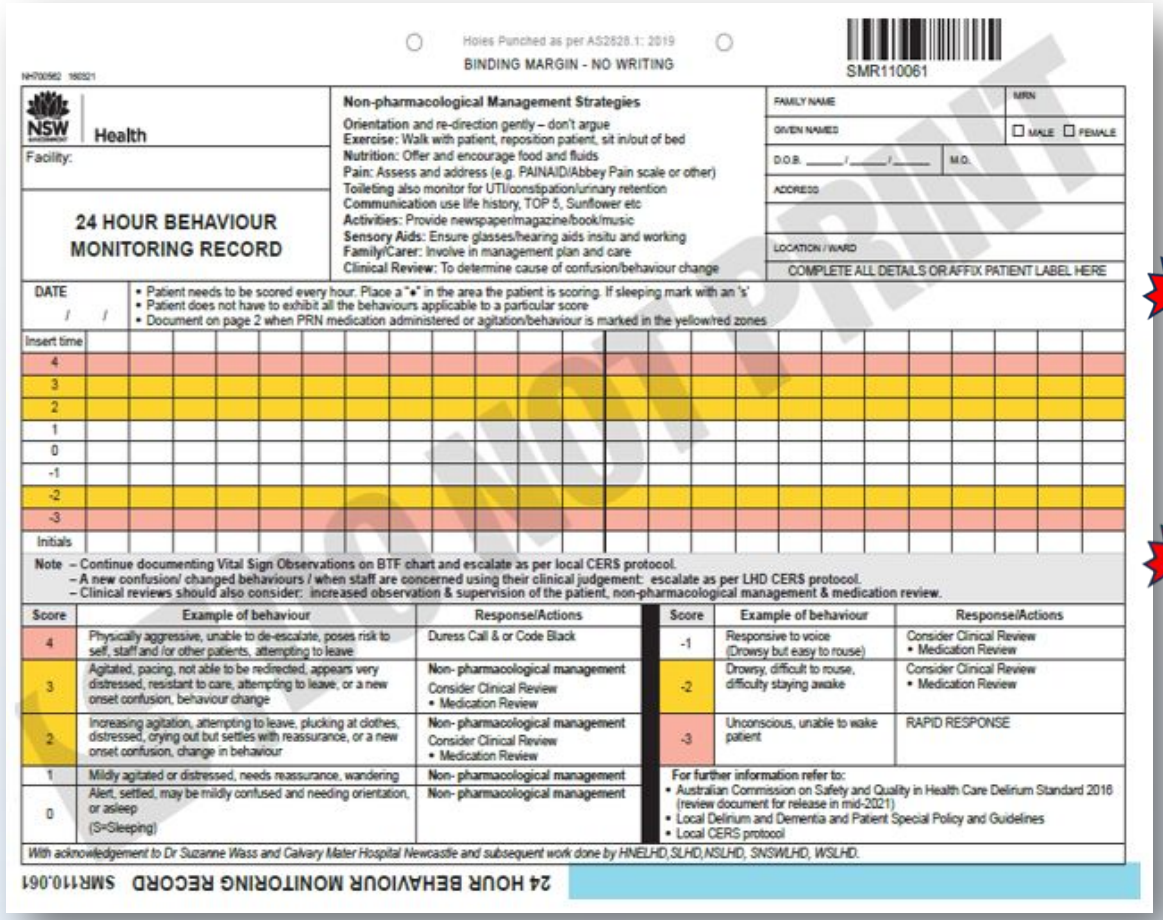
24-hour Behaviour Monitoring Record



Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

SMR110061

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Facility:

24 HOUR BEHAVIOUR MONITORING RECORD

Non-pharmacological Management Strategies

Orientation and re-direction gently – don't argue
Exercise: Walk with patient, reposition patient, sit in/out of bed
Nutrition: Offer and encourage food and fluids
Pain: Assess and address (e.g. PAINAID/Abbey Pain scale or other)
Toileting also monitor for UTI/constipation/urinary retention
Communication use life history, TOP 5, Sunflower etc
Activities: Provide newspaper/magazine/book/music
Sensory Aids: Ensure glasses/hearing aids insitu and working
Family/Carer: Involve in management plan and care
Clinical Review: To determine cause of confusion/behaviour change

FAMILY NAME | MRN
GIVEN NAMES | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DATE / /

- Patient needs to be scored every hour. Place a "•" in the area the patient is scoring. If sleeping mark with an 's'
- Patient does not have to exhibit all the behaviours applicable to a particular score
- Document on page 2 when PRN medication administered or agitation/behaviour is marked in the yellow/red zones

Insert time																								
4																								
3																								
2																								
1																								
0																								
-1																								
-2																								
-3																								
Initials																								

Note – Continue documenting Vital Sign Observations on BTF chart and escalate as per local CERS protocol.
– A new confusion/ changed behaviours / when staff are concerned using their clinical judgement: escalate as per LHD CERS protocol.
– Clinical reviews should also consider: increased observation & supervision of the patient, non-pharmacological management & medication review.

Score	Example of behaviour	Response/Actions
4	Physically aggressive, unable to de-escalate, poses risk to self, staff and /or other patients, attempting to leave	Duress Call & or Code Black
3	Agitated, pacing, not able to be redirected, appears very distressed, resistant to care, attempting to leave, or a new onset confusion, behaviour change	Non- pharmacological management Consider Clinical Review • Medication Review
2	Increasing agitation, attempting to leave, plucking at clothes, distressed, crying out but settles with reassurance, or a new onset confusion, change in behaviour	Non- pharmacological management Consider Clinical Review • Medication Review
1	Mildly agitated or distressed, needs reassurance, wandering	Non- pharmacological management
0	Alert, settled, may be mildly confused and needing orientation, or asleep (S=Sleeping)	Non- pharmacological management

Score	Example of behaviour	Response/Actions
-1	Responsive to voice (Drowsy but easy to rouse)	Consider Clinical Review • Medication Review
-2	Drowsy, difficult to rouse, difficulty staying awake	Consider Clinical Review • Medication Review
-3	Unconscious, unable to wake patient	RAPID RESPONSE

For further information refer to:
- Australian Commission on Safety and Quality in Health Care Delirium Standard 2016 (review document for release in mid-2021)
- Local Delirium and Dementia and Patient Special Policy and Guidelines
- Local CERS protocol

With acknowledgement to Dr Suzanne Wass and Calvary Mater Hospital Newcastle and subsequent work done by HNELHD,SLHD,NSLHD, SNSWLHD, WSLHD.

24 HOUR BEHAVIOUR MONITORING RECORD SMR110.061

Score 0: Alert, settled, may be mildly confused and needing orientation, or asleep.

Score 1: Mildly agitated or distressed, needs reassurance, wondering

Score 2: Increasing agitation, attempting to leave, plucking at clothes, distressed, crying out but settles with reassurance, new onset confusion, change in behaviour.

Score 3: Agitated, pacing, not able to be directed, appears very distressed, resistant to care, attempting to leave, or a new onset confusion, behaviour change.

Score 4: Physically aggressive, unable to de-escalate, poses risk to self, staff and/or patients, attempting to leave.

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What does BEST do?

Spend meaningful, quality time with patients

Identify and understand likes, dislikes, triggers, unmet need

Assist in crisis de-escalation

Provide distraction and diversional resources

Facilitate post incident debriefs

Collaborate with treating team in developing Behavioural Management Plans

Provide education to staff

Liaise with family/carers/friends to gather collateral

Act as patient support when receiving bad news, attending appointments, or where otherwise indicated

Data Collection

- Mix of quantitative and qualitative data:
- Pre and post implementation staff surveys
- Incident reporting system – IMS+
- Code Black data
- Patient Reported Experience Measures Survey (PREMS)
- Local working documents (Patient Activity Log/Patient list)
- Anecdotal feedback

BEST Reviews

Data from January 2023 – July 2024

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Average number of BEST reviews per month

(1 review = 30 mins average)

348

Average number of individual patients reviewed by BEST per month

71

Reason for referral

Agitation 54.3% and Delirium 31.2%

Year on Year (YoY) reduction in code blacks.

(Jan – Dec 2022 vs Jan – Dec 2023)

- 18

Change in incident type and severity of aggression.

↓9%

Promotion of incident reporting whilst delivery a reduction is IMS+ Harm scores 1,2 & 3

↑2.5%

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Data from November 2022 – July 2024

Sydney Local Health District

Staff confidence and capability

Data source: Pre and Post Staff Survey

Data from November 2022 – July 2024

BUILDING CONFIDENCE

Q1. I am confident identifying **triggers and escalating behaviours?**	+3%
Q2. I feel confident **caring for** and treating patients at risk of an Acute Behavioural Disturbance	+17%
Q3. I feel confident participating in my ward or departments **safety huddle**	+15%
Q4. After an Acute Behavioural Disturbance incident or a Code Black, I feel confident participating in a **debrief**	+2%

9%

BUILDING SKILLSETS

Q5. I am confident in my **de-escalation** skills	+9%
Q6. I am confident using the **24-hour behaviour management record**	+39%
Q7. I am confident developing **management plans** for Acute Behavioural Disturbance	+24%
Q8. I utilize **management plans** to guide how to care for or treat patients at risk of Acute Behavioural Disturbance	+10%

20%

BUILDING AWARENESS

Q9. The assessment and management of Acute Behavioural Disturbance is within my **scope of practice**	+10%
Q10. I have a clear understanding and **awareness of why** patients might exhibit Acute Behavioural Disturbance	+4%
Q11. I am aware of the **policies, guidelines and tools** available to me to help assess for and manage Acute Behavioural Disturbance	+21%

11%

Staff perception of BEST

Data source: Post Staff Survey

Measuring the mean results out of 5.00 (Likert Survey)

Six Month Post-Implementation Survey Only

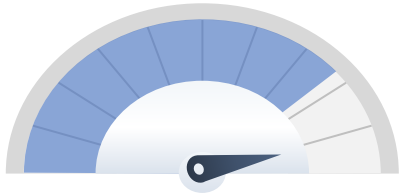
Overall Mean results **4.14**

High

Range		
4.20	5.00	Very High
3.40	4.19	High
2.60	3.39	Moderate
1.80	2.59	Low
1.00	1.79	Very Low

Q12. I believe BEST input assists the overall wellbeing of my patient's	
Nursing	4.16
Medical	4.12
Allied Health	4.51

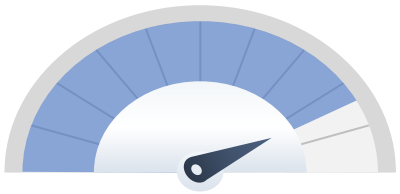
Very High



4.26

Q13. I have a clear understanding of when to refer a patient to BEST	
Nursing	4.04
Medical	3.86
Allied Health	4.04

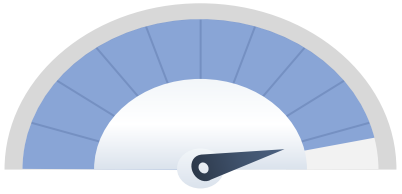
High



4.02

Q14. BEST have been visible and a readily available resource to my ward or department	
Nursing	4.16
Medical	4.23
Allied Health	4.52

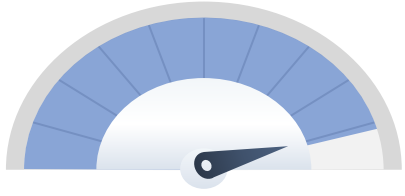
Very High



4.30

Q15. I feel supported by BEST when they are involved in the care of my patients	
Nursing	4.01
Medical	4.14
Allied Health	3.76

High



3.97

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Data from November 2022 – July 2024

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Staff, Patient, Family and Carer Feedback

Staff

"Thank you for all that you do. Especially your documentation, it creates such an in-depth view of the patient that gives us good insight into their behaviour“ – NUM

"BEST are invaluable to NS in de-escalation techniques and a general second pair of hands for pts who are confused and re-orientation is difficult. Their knowledge of the pt is also great for times BEST aren't there and the pt is upset, needs reassurance or is escalating towards a code black“ - Staff

Patient

“My heart beats when you come to see me” - Patient

"You bring about such a sense of calm, without you guys I would go crazy in here" "It's important that you understand how much you help me“ - Patient

“I feel I can trust you when you talk to me so I really like when you come to see me.” - Patient

Family and Carer

I don't think there would have been any improvement if it wasn't for your team. We would not have come this far without BEST. You're the BEST!“ – Family

“The care, respect and the consistency of visiting the patients and getting to know the patients as their family, We all looked forward to the visits of the BEST team. We loved the Tim Tams. Thank you, patient and our family are grateful for your caring visits.” - Family

References

Ballard, A., & Bozin, D. (2023). The true (financial) costs of workplace violence in Australia. *ALTERNATIVE LAW JOURNAL*, *48*(3), 191–196.

Cabilan, C., & Johnston, A. N. (2019). Review article: Identifying occupational violence patient risk factors and risk assessment tools in the emergency department: A scoping review. *Emergency Medicine Australasia*, *31*(5), 730–740. https://doi-org.ezproxy.utas.edu.au/10.1111/1742-6723.13362

Colvin, G. (2004). *Managing the cycle of acting-out behaviour in the classroom.* Eugene, Behaviour Associates.

Rosenthal, L. K., Byerly, A., Taylor, A. D., & Martinovich, Z. (2018). Impact and Prevalence of Physical and Verbal Violence Toward Healthcare Workers. *Psychomatics,* 59(6), 584-590.

Questions?

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