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Original Article

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Jeannine Loucks,[1] Dana N. Rutledge,[1,2] Beverly Hatch,[1] and Victoria Morrison[1]

Abstract

Behaviors of patients with psychiatric illness who are hospitalized on nonbehavioral health units can be difficult to address by staff members. Instituting a rapid response team to proactively de-escalate potential volatile situations on nonpsychiatric units in a hospital allows earlier treatment of behavioral issues with these patients. The behavioral emergency response team (BERT) consists of staff members (registered nurses, social workers) from behavioral health services who have experience in caring for patients with acute psychiatric disorders as well as competence in management of assaultive behavior. BERT services were trialed on a medical pulmonary unit; gradual housewide implementation occurred over 2 years. Tools developed for BERT include an activation algorithm, educational cue cards for staff, and a staff survey. Results of a performance improvement survey reveal that staff nurses have had positive experiences with BERT but that many nurses are still not comfortable caring for psychiatric patients on their units.

Keywords

rapid response team, psychiatric emergencies, behavioral health, psychiatric nursing, de-escalation, Iowa Model of Evidence-Based Practice

John, age 35 years, suffered from a severe and persistent mental illness, taking antipsychotic medications to control the voices in his head. John vacillated between moments of clarity and total fear. He looked for quiet places to hide. As with many people suffering from schizophrenia, John had no family or friends on whom he could rely.

Living on the streets, John cared poorly for himself. Admitted to our medical unit for pneumonia and malnutrition, he was placed in a single room at the end of the hall. He had minimal contact with nursing staff, who were put off by his disheveled appearance and bizarre behavior. When John talked about the daggers that might pierce his skin if he got into the shower, the nurses were afraid and did not know what to do for him. They stayed away.

One night the voices were so terrifying that John began to yell. The nurses were frightened. The charge nurse called the behavioral health unit and asked for the newly formed behavioral emergency response team (BERT). Within minutes, a nurse from the team responded and calmed John's fears with reassurance, reorientation, and support. The BERT nurse communicated with the treating physician, obtaining medication orders to help John regain control. She discussed techniques and communication strategies with staff nurses that might work with patients suffering from delusions and hallucinations. She also talked about prodromal symptoms of behavioral escalation, encouraging staff to call the team with any questions.

Introduction

Recommended by Institute for Healthcare Improvement (2004) to save patient lives, rapid response teams (RRTs) were initially developed to prevent deaths outside critical care units by providing specialized resource teams who could respond to patients in emergent situations. Composed of nurses, respiratory technicians, and physicians who bring critical care expertise to patients' bedsides, RRTs initiate early interventions that enhance outcomes for medical/surgical patients (Jolley, Bendyk, Holaday, Lombardozzi, & Harmon, 2007). Currently, the Joint Commission (2008), in its hospital National Patient

[1]Jeannine Loucks, RN-BC, BS, Dana N. Rutledge, RN, PhD, Beverly Hatch, RN-BC, MS, and Victoria Morrison, RN, MSN, FNP-BC, St. Joseph Hospital, Orange, CA, USA
[2]Dana N. Rutledge, RN, PhD, California State University Fullerton, Fullerton, CA, USA

Corresponding Author:
Jeannine Loucks, RN-BC, BS, Behavioral Heath, St. Joseph Hospital, 1100 West Stewart Drive, Orange, CA 92863-5600, USA
Email: jeannine.loucks@stjoe.org

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Safety Goals, requires a method to enable staff members to gain assistance from specialty personnel when they have recognized a potentially worsening change in patient condition. Following successful implementation of RRTs for medically deteriorating patients (Jamieson, Ferrell, & Rutledge, 2008), staff members of our hospital have implemented other response teams (Bogert, Ferrell, & Rutledge, in press). Our BERT team was developed to assist hospital staff in escalating situations related to nonbehavioral health services patients with psychiatric conditions. This article describes the development and implementation of the BERT team, which responds to the needs of people with mental illness to receive appropriate and therapeutic care in nonpsychiatric environments, and presents potential new roles for psychiatric nurses.

Background on Mental Illness

Mental illness affects approximately one in four U.S. adults in a given year (National Institute of Mental Health, 2008), and severely mentally ill persons suffer chronic medical illnesses at rates greater than those in the general population (Zolnierek, 2009). In fact, the mortality rates of these vulnerable people (those with psychiatric conditions plus co-occurring chronic diseases) are the highest of any population served by any agency of the U.S. Public Health Service (Parks, Svendsen, Singer, Foti, & Mauer, 2006). This makes it likely that persons with severe mental illness will seek care and be hospitalized for acute medical or surgical conditions. When hospitalized on nonpsychiatric units, behaviors of persons with schizophrenia, bipolar disorder, and dementia/delirium may confound medical/surgical nurses who are unaccustomed to dealing with these conditions. Medical/surgical staff need resources aimed to help them meet the challenges of behavioral issues related to the psychiatric conditions of these patients (Landers & Bonner, 2007).

Stigma, negative attitudes, and discrimination toward mental illness among nurses were themes uncovered in recent literature reviews (Ross & Goldner, 2009; Zolnierek, 2009). Patients with severe mental illness are often labeled *difficult*, although this may be influenced by nurse–patient encounters and factors in the hospital environment (e.g., desire for order and structure; Zolnierek, 2009).

Skills of Psychiatric Nurses

Psychiatric nurses are familiar with behavioral aberrations in patients with schizophrenia, bipolar disease, and dementia. In acute psychiatric units, nurses commonly observe patients for predictors of escalating behavior (Mackay, Paterson, & Cassells, 2005), allowing them to intervene prior to a negative event. Similarly, psychiatric nurses control the environment (tone, pace, activity level), trying to create a therapeutic milieu that may prevent patient behavioral escalation (Delaney, 1994). Psychiatric nurses are also familiar with medical treatment of behavioral emergencies (Allen et al., 2003) and can appropriately report signs and symptoms that might warrant pharmacologic interventions.

BERT was formed on the premise that trained and experienced psychiatric nurses would take the above-mentioned skills to nonpsychiatric hospital units where patients with psychiatric conditions were exhibiting risky or scary behaviors. BERT is an adaptation of our hospital's RRT for medically at-risk patients. It involves proactive strategies to de-escalate potentially volatile situations with behavioral health patients who are cared for on nonpsychiatric hospital units, and it is thus a unique type of RRT. A literature search using the CINAHL database looking for descriptions of such teams uncovered only one example (Lester, 2000), which described providing psychiatric services for combat stress control units.

What Is BERT?

BERT, the behavioral emergency response team, is a consultative resource that may be used when psychiatric behaviors present in a nonpsychiatric setting. Target behaviors are potentially disruptive or threatening actions of individuals with a psychiatric history or other patients who compromise the safety and well-being of selves, other patients, visitors, and staff members (see Figure 1). An example of a recent call: the charge nurse from the medical pulmonary unit called the BERT team and asked for help with a young man's belligerent behavior that included verbal abuse to staff members and behaviors such as throwing trays and full urine bottle. The 34-year old male paraplegic, admitted for potential pneumonia and chronic wounds, had a history of schizoaffective disorder. The BERT nurse assessed that the man was probably developmentally delayed and was guarded and suspicious of others; his behaviors seemed to be triggered by lack of control over his environment. She intervened by using appropriate limit setting and calm verbalizations; she called her assessment to his physician, who ordered appropriate as-needed or prn medications. Once medication was administered, the nurse remained on the unit and discussed the case with the staff, using this opportunity to reinforce the BERT algorithm (Figure 1) and to discuss the patient's condition, his behaviors, and interventions that may be successful in preventing future problems.

The BERT team is composed of staff members (registered nurses, social workers) from our inpatient behavioral health services (BHS) who have experience in caring for patients with acute psychiatric disorders as well as competence in management of assaultive behavior. In some cases these staff members must be able to determine if

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BERT Members	Methods to Identify Patients for BERT	Methods to Activate BERT	Methods to Communicate	Methods to Incorporate BERT Into the Care Process	Methods to Measure the Effectiveness
• Behavioral Health Services (BHS) Registered Nurse with Management of Assaultive Behavior Designation to write 72 hour holds • BHS social worker • BHS Clinical Coordinator / Charge Nurse / Department Manager	• Response criteria: • Acutely agitated patient [i.e., yelling, threatening, demanding, cursing, responding to hallucinations or delusions] • Patient in distress with deteriorating condition • Patient at risk for: danger to self, danger to someone else • Patient who is confused and threatening to leave hospital Against Medical Advice. • Patient experiencing drug/alcohol withdrawal signs or symptoms, and exhibiting acting out behavior.	• Call Behavioral Health Services. State "Need BERT to room [XXXX]." • BHS staff will alert house supervisor that BERT has been called.	• BHS RN will assess patient condition and facilitate stabilization of patient behavior. • BHS Clinical Coordinator/Charge Nurse will collaborate with assigned RN to modify or implement appropriate plan of care. • BHS Clinical Coordinator/Charge Nurse will document briefly in progress notes regarding consultation call utilizing SBAR and will complete BHS BERT form. • BHS Nurse will place BERT form in Log Book. • The Supervisor will note that BERT was deployed to unit _____ on "Administrative Report."	• Awareness of BERT among MDs through committees, Medical Staff Briefs, etc. • Awareness of BERT among nurses through staff meetings, unit newsletters, daily hospital newsletter, flyers, and Nurse Leadership Team, etc.	• Positive feedback from physicians and staff • Monthly trending of numbers of patients treated and stabilized. • Staff surveys regarding knowledge/ attitudes (January 2009) • Debriefings of BERT calls (2 per month) Begun March 2009

Figure 1. BERT algorithm

the patient requires involuntary psychiatric treatment and are designated to initiate an involuntary hold if the need is present.[1] The BERT team members are not "dedicated" to this role but come from on-duty BHS staff. Our hospital is a 500+ bed Magnet facility in southern California. We have 36 inpatient adult psychiatric beds representing a full spectrum of psychiatric diagnoses, with patients who often present with comorbid medical conditions. Although patients must be 18 years of age, there is no upper age limit for patient admission. We also have an outpatient program that predominately treats patients with chronic depression and bipolar conditions.

BERT is activated when a nurse from the inpatient unit notifies the BHS unit of a problem situation. This call leads to notification of the house supervisor. Depending on the nature of the call (e.g., exact scenario, its urgency), one or more BERT team members go to the calling unit. Team members assess the patient, and depending on the situation, they put strategies into action to stabilize the patient and defuse problems. The actions of the BERT team promote role modeling of psychiatric interventions to nonpsychiatric personnel, which may enhance skills in medical–surgical staff members and promote their confidence in addressing similar issues in the future. When the situation is defused, a BERT team member debriefs with unit staff, doing one-to-one teaching as needed regarding the situation.

The value-added service provided by BERT is timely consultation and intervention to assure adequate risk screening, situational assessment, and relevant interventions for patients, along with assistance to staff.

BERT Implementation

Use of the Iowa Model of Evidence-Based Practice (Titler, Steelman, Budreau, Buckwalter, & Goode, 2001) aided our systematic approach to BERT. This model directs decision making from problem identification

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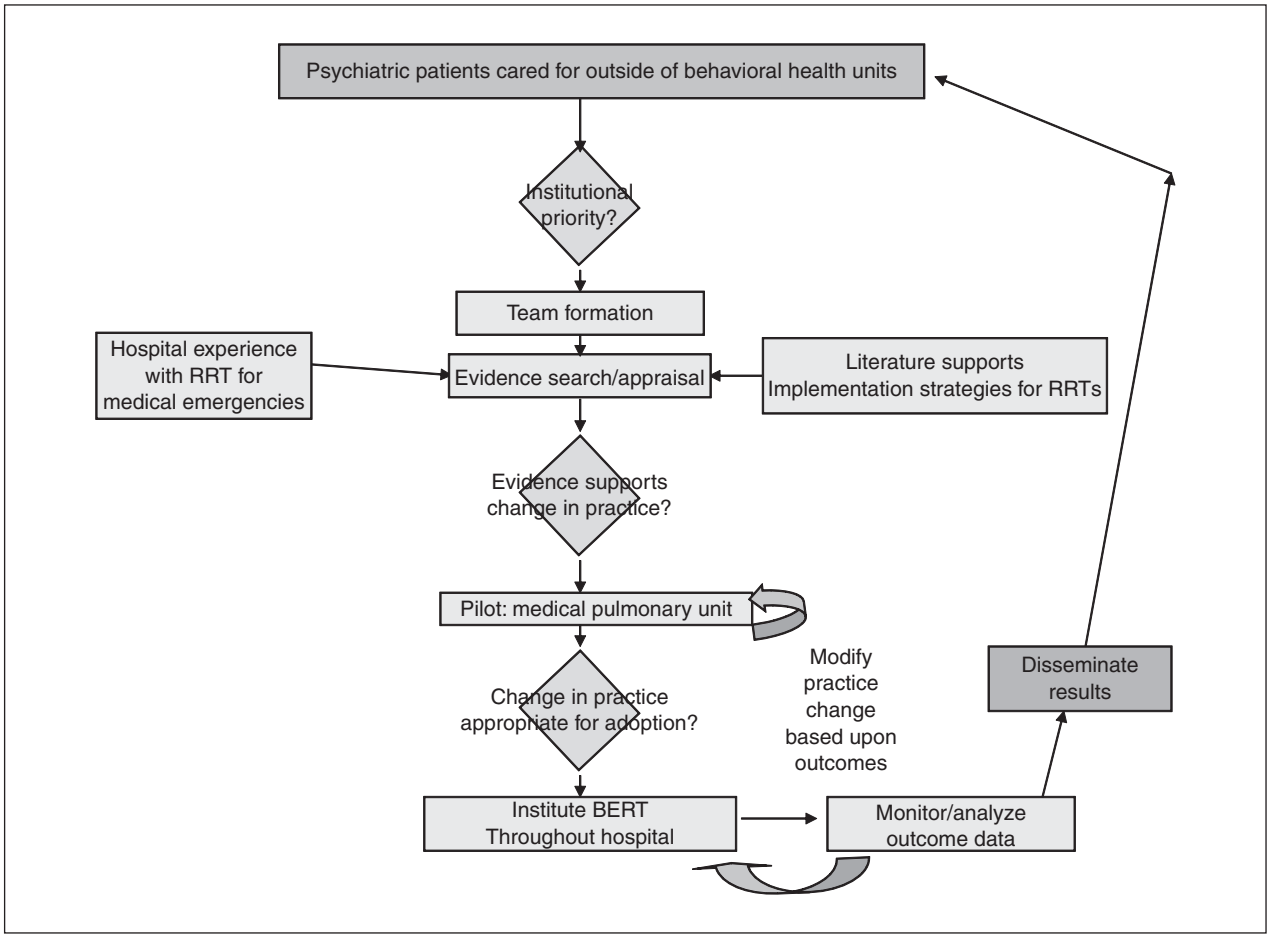

Figure 2. Process used for BERT implementation

through evidence searching and appraisal to evaluation of an evidence-based intervention or practice. Key decision points in this process model involve three questions: (a) Should the stated problem be addressed as an institutional priority (e.g., "Should resources be put into addressing it?")? (b) Does the evidence support a practice change? (c) Does implementation of the change lead to desired outcomes, which may be patient, staff, or organizational? A diagrammatic portrayal of our process is seen in Figure 2, where these decision points are seen as diamonds in the figure.

Hospital administration prioritized BERT as an initiative worthy of resource allocation. Discussion regarding care and treatment of psychiatric and behavioral health patients on medical units began in 2006 with the executive director of Critical Care Services (EDCCS), nurse managers of a medical–surgical unit and BHS, and BHS nurses. The "trigger" to these discussions was a series of patient problems. The EDCCS shared strategies and lessons learned while implementing the RRT (Jamieson et al., 2008). Benefits realized by the RRT included reduction in numbers of resuscitations, greater collaboration between staff nurses and critical care, improved communication through use of situation, background, assessment, recommendation (SBAR), and better outcomes for patients. Challenges to implementing the RRT included attitudinal differences between critical care nurses on the team and medical–surgical nurses, culture shift regarding proactive rather than reactive care, staffing level adjustments, and physician education and participation (Jamieson et al., 2008). Thomas, Force, Rasmussen, Dodd, and Whildin (2007) found consistent communication among team members and receiving staff essential during the initial education and implementation phase of an RRT. We found no literature on psychiatric RRTs. The in-house evidence and literature about RRTs (see Figure 2) was deemed credible and pointed us to develop and implement a similar response team for psychiatric emergencies on nonpsychiatric units. Thus, per the process guided by the Iowa Model (Titler et al., 2001), a

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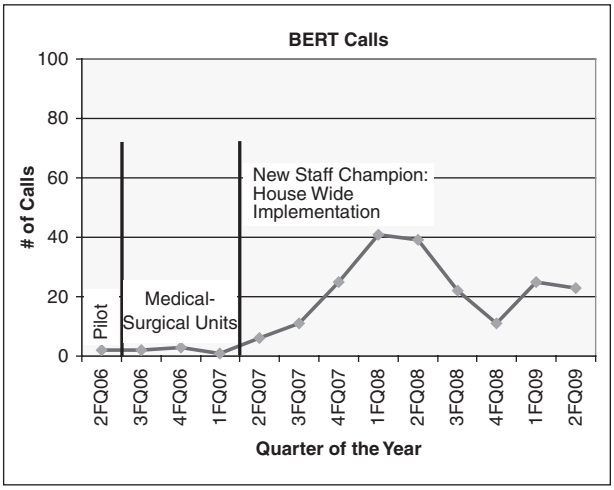

Figure 3. BERT calls

pilot program was planned to determine fit and feasibility of the team.

Pilot

BERT was piloted January through April 2006 on the medical pulmonary unit. This unit was selected because it has medical patients with a high incidence of comorbid psychiatric issues; on average, three to four psychiatric patients per month are admitted for a variety of disorders. Initial staff education consisted of staff in-services on specific BERT team guidelines (e.g., team member, methods to identify patients, methods to activate BERT, methods to communicate, floor RN responsibilities, BERT staff responsibilities). During the pilot, there were four BERT calls that led to positive patient outcomes and anecdotal evidence of staff satisfaction. After the first two calls, the team determined a need for more structure in staff assessment and for criteria that should drive a BERT call; they developed an algorithm for hospital staff to delineate early warning signs of escalation and how to activate the BERT team (see Figure 1 for current algorithm). The algorithm was shared with staff nurses during educational sessions on the pilot unit by the BHS nurse manager. The initial algorithm underwent several rounds of changes subsequent to the pilot and early implementation, which focused only on medical–surgical units. This initial implementation was slow, with an average of one to three calls per month (Figure 3). With the Iowa Model, full-scale implementation occurs after a successful pilot. Based on our available resources, we decided on gradual implementation (medical surgical units, then women's health and critical care, and finally the emergency department).

2007

- Jan 4 – Presentation to Clinical Leadership
- Jan 16 - Clinical Educator – completion of "Suicide Risk" module w/educator
- Jan 18 – Presentation to Nursing Leadership Team
- Feb 8 – Presentation to Risk Management Department
- Feb 12 – Presentation to Emergency Department physicians/staff
- Apr 2 – Presentation to Medical Surgical units
- Apr 13 – Presentation to O.C. Health Care Agency Patients Rights Office
- May 25 – Presentation to Clinical Education

2008

- Jan 16 – Medical Surgical staff update
- Feb 13 – Orthopedic Unit staff update
- Apr 2 – Behavioral Health Services Management Team update
- May – Hospital Skills Days
- Sep 15 – Medical Pulmonary Unit – 2 Hour training (requested by nurse manager)
- Sep 23 – Emergency Department physicians - update
- Oct 1 – Onsite associate degree nursing students - inservice
- Oct 9 – Conference Call with Health System Risk Managers and Directors

Figure 4. BERT educational activities

Housewide Implementation

In January 2007, a BHS clinical coordinator (JL, first author) became staff champion for BERT with the goal of housewide implementation. Implementation steps mirrored those used in the pilot phase. During 2007 and 2008, multiple outreach efforts (Figure 4) were done to enhance BERT visibility, help staff to understand its purpose and how to access it, and prevent miscommunications. The staff champion developed behavioral cue sheets to assist nurses in identifying psychiatric behaviors that may increase risk for agitation (Figure 5) and features of mental illness (Figure 6). These are shared in all educational efforts, along with the BERT algorithm. BERT calls increased following the increased internal marketing (Figure 3) up to a high in the first quarter of 2008 of 41 calls coming from throughout the hospital.

We were interested in learning about responses of the unit staff nurses in terms of their knowledge of and experiences with the BERT team along with their comfort level with caring for psychiatric patients on their units. Over 2 weeks during the first quarter of 2009, the first and fourth authors walked through the nine units and asked on-duty nurses to respond to a short survey related to BERT (questions found in Table 1). Nurses did not have to have

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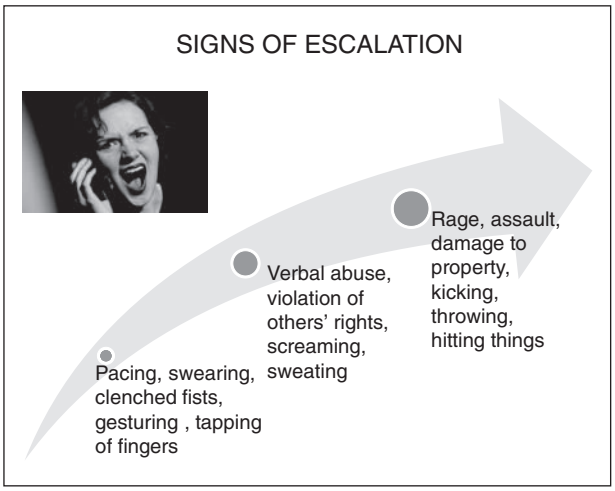

Figure 5. Cue card: Behavioral escalation

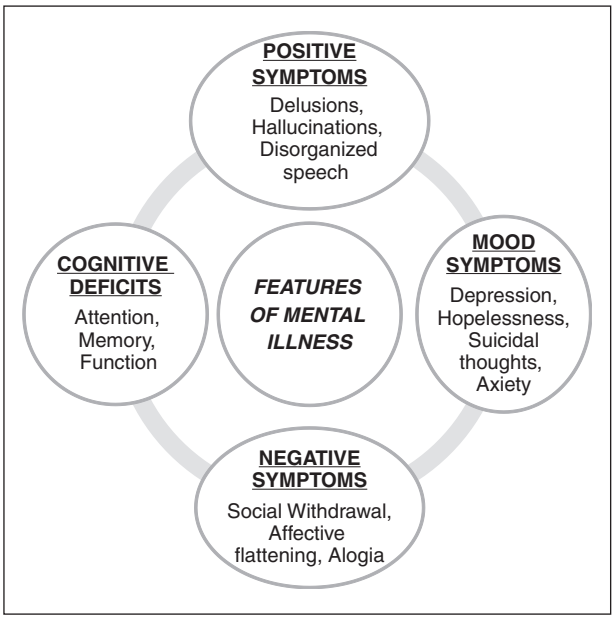

Figure 6. Cue card: Features of mental illness

experience with the BERT team. All invited nurses participated. Nurses either completed the survey on the unit and returned to the author or requested to be interviewed by phone (less than 5 nurses). Nurses represented both day and night shifts and all nine units where BERT is used. Of 39 nurses, 54% consider their understanding of BERT to be clear (4/5 on a Likert-type scale; Table 1) whereas only 31% report that their level of comfort in caring for psychiatric patients is high (4/5; Table 1). Of the 39 nurses interviewed, 14 (36%) had been involved in a BERT call, and all believed patients' needs were met. At the same time of the staff survey, a debriefing form was developed to gain information following BERT calls. This form was used initially for three calls from February 2009 (Table 2) and proved to be quite helpful. Currently, BERT team members are evaluating at least 50% of their calls using the debriefing form. Over time, issues that are discovered can be addressed.

Because a goal of the BERT team is seamless, collaborative care, patients were not surveyed because they would be unlikely to know that the BERT team was activated on their behalf.

Discussion

BERT has allowed nurses on nonpsychiatric units to access specially trained behavioral health nurses to assist in potentially dangerous or deleterious situations. Where previously nurses approached caring for patients with mental illness with skepticism and fear, they can now use knowledge gained by BERT team members and BERT itself when necessary. By reaching out to BERT with accurate assessment of a patient in need, nurses show their compassion and caring. This caring supports the American Nurses Association (2001) Code of Ethics Tenet 1 that "nurses practice with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems."

Different models have been used to assist nonpsychiatric practitioners deal with psychiatric patients, most commonly consultation–liaison services that lead to patient/nurse satisfaction but none offer evidence of altered patient outcomes or cost savings (Zolnierek, 2009). Strategies also include designated psychiatric emergency services (Woo, Chan, Ghobrial, & Sevilla, 2007) and advanced practice nurses in the emergency department (Karshmer & Hales, 1997; Wand & Fisher, 2006) or as liaisons (Wand, 2004). The BERT team offers another care model, one that can be implemented in settings where psychiatric nurses are available to assist staff. The lack of patient and cost outcomes for BERT is a limitation of our evaluation.

Implementation of a practice change such as BERT is streamlined using a systematic approach such as that delineated in the Iowa Model (Titler et al., 2001). By linking a practice problem to credible evidence and strategic planning, implementation—although not easy—was informed by evaluation of outcomes from the pilot and subsequent subphases (medical–surgical, women's health/critical care, emergency department). BERT team members gained insights at each phase.

Plans for BERT at our hospital include continuing performance improvement with monthly debriefings of at least three to four BERT calls and intermittent staff

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Table 1. Staff Responses to Survey Focused on Perceptions to Caring for Patients With Psychiatric Conditions and Using BERT (*N* = 39)

	1 (*n*, %)	2 (*n*, %)	3 (*n*, %)	4 (*n*, %)	5 (*n*, %)
What is your understanding of the BERT team?[a]	5 (13)	6 (15)	7 (18)	11 (28)	10 (26)
What is your level of comfort in caring for psychiatric patients on your unit?[b]	1 (2)	4 (10)	20 (51)	9 (23)	3 (8)
Describe the rapport between Behavioral Health and staff on your unit/ department.[c]	0	1 (2)	12 (31)	7 (18)	11 (28)
	0	1	2	3	>4
How many times have you called for the BERT team?	24 (62)	10 (26)	4 (10)	0	0
If you called for the BERT team, were your patient's needs met by the response?	Of those who had called, 100% Yes				
Written comments from survey:					
What is the BERT team? (Emergency Department nurse)					
I haven't known anyone on our team who has called the BERT team. But I am aware they exist. (Orthopedics nurse)					
We rarely use the BERT team. The one time we used their services the RN responded quickly and was very friendly and professional. (Orthopedics nurse)					
I was unsure if the BERT team was an appropriate resource and when the call was finished it was clear that it was. The nurse was very helpful and helped me have a clearer understanding of the purpose of the resource. (Unknown unit of origin)					

Note: BERT = behavioral emergency response team.
a. 1 = *Never heard of BERT*; 3 = *Somewhat understand*; 5 = *Clear understanding*.
b. 1 = *Low comfort level*; 3 = *Somewhat comfortable*; 5 = *High comfort level*.
c. 1 = *Poor rapport*; 3 = *Good*; 5 = *Excellent*.

Table 2. Three Calls from February 2009 with Debriefing Information (follow-up by BHS Nurse Manager)

Call	Call Details	Follow-Up
Call 1	Call from CVICU by clinical coordinator who desired guidance about a patient admitted for overdose on multiple over-the-counter medications. Minimal communication had occurred between admitting emergency department staff and ICU staff about the patient's psychological status. Patient was cooperative.	A fast response from the night BERT team nurse. Psychiatric consult arranged. When patient was medically cleared, was transferred to BHS.
		There was no need for follow-up support for individuals involved. Clinical coordinator noted "the response was excellent, awesome, helpful!"
Call 2	Call from medical pulmonary unit by the charge nurse who was notified by staff that a psychiatric patient exhibited escalating behaviors (e.g., getting out of bed, hallucinating, no longer tolerant of roommate). Patient's unpredictable and demanding behavior left staff feeling unprepared as to how to approach patient effectively.	BERT response was quick and appropriate. BERT nurse helped debrief the patient and let him ventilate about his experience. Staff felt like BERT nurses showed them how to intervene with this patient.
Call 3	Call from labor and delivery nurse about a patient who had been admitted in early labor, which stopped. The patient became tearful and upset as she spoke about an incident in which the baby's father was threatening her; she verbalized fear. The nurse wanted someone to assess whether or not the patient was safe to return home.	BERT nurse made a timely respond, guiding the patient and staff about how to leave the hospital safely. The patient's father agreed to stay with her. The patient was to avoid contact with the baby's father and return to therapy with a counselor; she was referred to the hospital postpartum depression program.

Note: CVICU = cardiovascular intensive care unit; ICU = intensive care unit; BERT = behavioral emergency response team; BHS = behavioral health services.

surveys, continuing to enhance awareness of BERT across the hospital, development of a self-learning module for new BERT team members addressing role expectations and training strategies, and creation of new preventive and intervention tools for nonpsychiatric nurses. At some point, as staff on nonpsychiatric units gain knowledge and confidence in dealing with this vulnerable population, BERT calls should diminish substantially.

Staff from hospitals with psychiatric or behavioral health units may want to consider establishing an RRT

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like BERT for behavioral emergencies. The tools that we have developed and the ideas for performance improvement discussed in this article may help provide a starting place to plan such a service.

Declaration of Conflicting Interests

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Note

1. The term *designation* is authorization bestowed to clinicians by the Orange County Health Care Agency Behavioral Health Services following successful completion of a hospital-offered class and demonstration of competency.

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