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## “Code Grey— Pip3—Male Side” “This Is The Head Nurse”

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The title of this article contains a series of actions that activate a procedure that summons staff through individual pagers and an overhead announcement to respond to one of two acute behavioral health inpatient units to assist in preventing or de-escalating a crisis. The criteria for activation of this team can be, but are not limited to, a patient exhibiting severe agitation, yelling, threats, exhibiting violence, and/or displaying any acute change in mental status.

Psychiatric inpatient units provide acute care for patients that have been admitted involuntarily, who often present with histories of violence and/or suicide attempts, and who are identified as at a high risk for becoming severely agitated and possibly violent during their hospital stay, which could result in the use of restraints and/or seclusion. Patients treated on inpatient units exhibit a range of fluctuations in their mental status that reflect the progress in their recovery and psychosocial influences. However, a common scenario often reported is that a patient “exploded without warning and required intramuscular medication and restraints.” The signs and symptoms of increasing anxiety, or subtle changes in mental

status, may have been evident prior to the explosion, or may have been undetected or ignored due to staff’s fear or lack of training. The staff who deal with the explosive patient are primarily nurses, but the psychiatrist and, if necessary, the hospital police are brought in to resolve the “explosion.” This practice of reacting to a crisis is no longer acceptable. Rather, the emphasis is on how we can prevent these situations from occurring.

The trend in our Behavioral Health on acute inpatient units in recent years has been to encourage a culture that is therapeutic, and that uses fewer invasive interventions, such as restraints, seclusion, and intramuscular medication. Historically, patients on psychiatric inpatient units would frequently exhibit agitation that would be allowed to escalate to levels that resulted in the use of restraints and/or seclusion. Not only would this invasive method to control the patient be utilized, but the length of time these forms of intervention were used could be excessive. Nursing staff assumed the lead role in attempting to defuse the situation; however, the behavior was often already at a crisis level. This results in not only hospital police presence, but their assistance in the actual physical

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intervention toward the patient. The psychiatrist's role would include evaluation of the patient, resulting in orders for intramuscular medication with restraints or seclusion due to the dangerousness of the situation. Frequent scenarios would have staff, including hospital police and nursing staff, physically restraining an agitated patient in a highly tense and dangerous situation while a nurse administered intramuscular medication. The staff would place the same patient in restraints or seclusion. The risk for injury was always high during these encounters.

Today the use of restraint and seclusion is considered only as a last resort to be used only if all other options fail. The use of intramuscular medication has also been under scrutiny regarding its therapeutic effect versus its invasive aspect. The practice of intramuscular medication and physical intervention can be dangerous and places patients and staff in unsafe situations that may have been avoided. In today's world, the practice of these modalities is often viewed as an actual treatment failure. This is particularly true if these modalities are viewed as a form of trauma not only to the patients but to staff as well.

Our Behavioral Health Department decided it was time to create a climate that would influence the entire staff on our inpatient units to participate in a proactive approach to intervening with potentially escalating dangerous situations before crises could erupt. Inpatient staff agreed that perhaps with early intervention and preventative strategies, many of these events might be avoided, resulting in a more compassionate and therapeutic milieu for the

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patients. In addition, the idea to incorporate other disciplines into being proactive and part of a team would help avoid invasive means of controlling behavior. Current teams on our inpatient units were limited to shift, unit, and discipline (generally nursing staff, a psychiatrist, and off-unit hospital police). The decision at Coney Island Hospital Department

of Behavioral Health was to move forward toward changing the culture on the inpatient units to discourage the use of invasive means of controlling behavior such as restraints or seclusion.

Coney Island Hospital, located in Brooklyn, is one of eleven hospitals affiliated with New York City Health and Hospital Corporation. It is a 371-bed community hospital that provides service to southern Brooklyn residents. The Behavioral Health Department includes a psychiatric emergency department within the medical emergency department, two 32-bed psychiatric inpatient units, psychiatric outpatient programs, and a chemical dependency program (outpatient and inpatient).

In early 2007, a multidisciplinary committee was formed with the mission to develop a program that would provide an approach that would be more therapeutic, compassionate, and safe in preventing incidents of escalating agitated behavior that culminates in crisis and often violence. The committee included clinicians and administrators as well as representatives from hospital police and the information technology (IT) department. The vision of this committee was to provide the best practice in the prevention aspects of escalated behaviors which included recognition of the early symptoms often exhibited by patients. The committee collected data regarding how other hospitals were handling these incidents and also conducted an employee survey of all the inpatient staff on all tours of duty regarding their attitudes related to safety. The overall theme that this survey revealed was that staff often felt afraid and that they did not work as an effective team in crisis situations. Many staff identified that they did not feel

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they had adequate training in symptom recognition and de-escalation strategies that used verbal means to intervene, rather than physical force. The committee also investigated what actually was reported to be occurring prior to the actual use of restraints—not only the patient's behavior but the staff's behavior as well. Identified leaders and cohesive working teams were described as ineffective and inadequate due to confusion, poor communication, and, primarily, failure to respond to early warning signs of increasing anxiety exhibited by the patient.

The development of the psychiatric crisis prevention team called Code Grey on the Coney Island Behavioral Health Inpatient Units was our response to wanting to change the old culture. We wanted to handle violence, potential violence, escalating behavior, and/or aggression through the safest, least restrictive means possible. We wanted our staff to have the knowledge and skills to move from a reactive to a primarily preventative practice. The goal is to provide assistance to the patient in regaining control of his/her behavior through the best possible *Care, Welfare, Safety, and Security*<sup>SM</sup> not only for the identified patient, but for other patients and staff as well. The Code Grey Team was defined as an interdisciplinary team that has received training in *Nonviolent*

*Crisis Intervention*<sup>®</sup> techniques and would be available to respond when a code was activated.

The Code Grey Team evolved over several months of meetings whose agenda included but was not limited to the following:

First, the development of a policy and procedure reflective of our philosophy to avoid the use of restraints and seclusion through early intervention by the provision of a trained team of staff to assist in de-escalating potentially dangerous psychiatric emergencies in a safe, compassionate, and respectful manner.

Second, the identification of the learning needs and necessary training for all clinical staff and hospital police to be able to intervene at the initial signs of increasing anxiety or agitation.

Third, the coordination of services pertaining to staffing, communication (written and verbal), and evaluation.

The inpatient staff, including many of our administrators and hospital police officers, was trained in this new initiative and in the expectation that each one of them on a

rotational basis would participate as a team member during their shift or assignment.

The Code Grey Team is comprised predominantly of inpatient nursing staff; however other key members include clinical administrators, inpatient therapists, psychiatrists, and hospital police. During the planning phase of this initiative, a number of staff were selected to attend CPI's four-day certification program to become *Nonviolent Crisis Intervention*<sup>®</sup> Certified Instructors. To date we have 19 Instructors that are utilized to provide training on all shifts on a monthly basis. All staff assigned to the team have received formal *Nonviolent Crisis Intervention*<sup>®</sup> training by attending an eight-hour program conducted here at Coney Island Hospital by one of our Certified Instructors. Initially, the training was targeted at staff working in the acute psychiatric care areas, which was only the staff assigned to the Code Grey Team. Presently, all staff working in the Behavioral Health Department are expected to attend training at least annually, and the acute care area (inpatient and psychiatric emergency) staff attend more frequently.



The leader during these codes is referred to as the team leader. The team leader is usually the nurse, although this can change during the actual code depending on how the patient responds. The team leader is often the staff member who directs another team member to call for a code and continues to interact with the patient. Team leaders generally have the best rapport with the patient, the confidence to de-escalate the situation, and are aware of the events leading up to the behavior change that necessitates the code. The team is alerted when a member dials a four-digit code that activates not only individual pagers carried by team members, but also an overhead intercom announcement. The team uses the SBAR (Situation, Background, Assessment, and Recommendation) system to quickly communicate key information about the incident to arriving team members, including whether the patient has a history of violent behavior or other pertinent factors.

A number of positive trends have emerged over the past year since introducing Code Grey. We have seen interest on the part of our staff to continue to learn about crisis prevention, and we have observed

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staff motivation to attend trainings not only as students, but also as instructors. Many of our newer instructors have reported positive feedback in their own skills to effectively intervene in potentially volatile situations in their clinical areas, including in the team leader role.

Learning is ongoing and occurs with each code, after which there is a debriefing that focuses on the patient and staff responses. This debriefing provides an opportunity for the exchange of a great deal of information, and learning from each other as well. We also discovered

that this new team is a means that enhances shared governance (team building) at the grassroots level across the entire inpatient staff, including hospital police and clinical administrators. In the past, staff who were reluctant to share their opinions or who were adversarial have now become active participants in this process. Finally, this model resulted in the empowerment of staff and patients, a greater collaboration, and overall improvement for patient and staff satisfaction relating to treatment. In addition to the individual debriefing following each Code Grey, there is a monthly meeting to review difficult cases and share performance data related to crisis prevention.

We have been very excited by the results of Code Grey. Code Grey was introduced to the units in December 2008. The number of episodes of restraints and seclusion averaged 8.3 per quarter in January through November 2008. There was an immediate improvement in decreasing the use of restraints and seclusion as evidenced by the quarterly average being reduced to 2.5 per quarter of 2009. Similarly, the total number of patient/staff injuries resulting from agitation-related incidents on the inpatient units decreased from 0.1 per month in 2008 to 0.016 per month in 2009. The Code Grey 2009 data has indicated a trend for staff intervention to occur prior to the patient exhibiting dangerous behavior. This is supported by the total number of Code Greys (136), resulting in only 10 episodes of restraints or seclusion for this year.

The plans for the future include continuing to reduce the use of restraints and seclusion. In the spirit to provide the least restrictive and safest intervention possible, this also includes reducing the use of intramuscular medication. To



sustain this proactive preventive initiative, ongoing CPI education programs, monthly meetings for critique and data review, and daily inpatient treatment team meetings that address the symptoms of potentially escalating behaviors and/or high risk patients have become a central part of our culture.

Beginning in 2010 we have started to have unannounced behavioral mock codes in which staff are expected to respond as if the mock codes were actual incidents. The drills provide excellent teaching opportunities, and they assist staff in practicing what they learn in *Nonviolent Crisis Intervention*<sup>®</sup> trainings in a controlled situation. These mock codes also serve to raise staff sensitivity to how patients may feel resulting from feedback from staff who assumed the role of the agitated patient during these teaching experiences. Staff enthusiasm during the debriefings, following both mock codes and true codes, continues to encourage dialogue that builds a stronger and more cohesive team.

The impact of our initiative outside of our Behavioral Health Department has also been evident in our hospital. Staff from Medicine, the Emergency Department, and Pediatrics have requested to participate in our programs in order to be better able to intervene in a positive, proactive approach with their patients. The role of patient, whether in Behavioral Health or Medicine, remains a role that is stressful, and, as a result, can escalate to crisis situations that result in violence. Discussions to explore and perhaps create a team to assist or serve as consults in these potentially volatile situations are beginning to be considered for these areas outside of our Behavioral Health Department. ■

## About the Authors:



(from left to right) Donna Leno Gordon and Janet Ferguson

Janet Ferguson, RN, is the Associate Director of Behavioral Health Nursing at Coney Island Hospital. Ms. Ferguson holds a degree from Downstate College of Nursing and a Master of Science in Nursing from Hunter Bellevue College of Nursing. She is board certified as an ANA Clinical Nurse Specialist in Adult Psychiatric and Mental Health. Ms. Ferguson is certified as a *Nonviolent Crisis Intervention*<sup>®</sup> Instructor through CPI and a Basic Life Support Instructor through the American Heart Association.

Ms. Ferguson has an extensive professional background that includes a broad portfolio of programs. She has participated as administrator, educator, and practitioner across a wide range of health care settings including Acute Care Psychiatry, Partial Hospitalization Program, Mental Health, Homecare, and Medical Surgical Nursing. In addition to her Coney Island responsibilities, Ms. Ferguson has been and continues to remain involved with educating nursing students regarding Behavioral Health through her adjunct role at several local colleges. Ms. Ferguson's primary focus throughout her career has been the care of the acutely mentally ill patients in the inpatient and psychiatric emergency department.

Donna Leno Gordon, RN, is the Director of Behavioral Health Nursing and Palliative Care at Coney Island Hospital. Ms. Leno Gordon holds a degree in nursing from Pace University, a Master of Science in Family Counseling from Iona College and an Executive Masters in Public Administration from Baruch College. Ms. Leno Gordon has extensive experience and a broad portfolio of programs she has designed and administered across a wide range of care settings including Rehabilitation, Critical Care, Hospice & Palliative Care, Homecare, Mental Health, Consultation Liaison Psychiatry, and Chemical Dependency.

Ms. Leno Gordon is currently co-chair of the Corporate Wide Palliative Care Council as well as the Nursing Director for Behavioral Health where she and the behavioral health team earned the 2009 Patient Safety Champion Award for Coney Island Hospital for their "Code Grey" Psychiatric Crisis Prevention Team and the 2009 Annual Behavioral Health Best Practice Award for their "Agitated Patient Management Team," assessing and treating acutely agitated patients immediately entering the Emergency Department.



Staff at Coney Island Hospital