

Team Meeting for Level 3/Level 4 Threat

Last Name/Room Number:	
Threat Level:	
Date of Event:	
Start Time of Meeting:	
End Time of Meeting:	

Purpose of Meeting:	<ul style="list-style-type: none"> ✓ Reset and identify need for additional support ✓ Prioritize subsequent actions and care ✓ Gather additional information for learning purposes
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1. Bedside nurse, SL or CSL sends an AYC page:
 - a. Patient with escalating violent behaviors triggering criteria for safety plan implementation. Could you call to discuss when you have a chance?
2. On that phone call, use SBAR format to schedule meeting:
 - a. Situation: Be succinct and specific such as "The patient in room XXXX is confused and kicked a nurse." or "The patient in room YYYY sexually assaulted one of our care partners."
 - b. Background: We have a pathway in place to help get medical, nursing, behavioral, and administrative representation in a quick 10-15 min meeting to help establish a plan and remove barriers to executing that plan.
 - c. Assessment: We'd like to have that meeting today to start that process.
 - d. Recommendation: Could I send you a Zoom link for a time that works best for you?

Patient WITHOUT Decision Making Capacity <input type="checkbox"/>	
Role:	Name:
Shift Leader/Manager <i>(Required-Lead meeting)</i>	
Attending or Representative of Primary Team <i>(Required)</i>	
Primary Nurse <i>(Required)</i>	
Social Work: <i>(Optional)</i>	
Case Manager: <i>(Optional)</i>	
Other:	
Other:	

Patient WITH Decision Making Capacity <input type="checkbox"/>	
Role:	Name:
Shift Leader/Manager <i>(Required-Lead meeting)</i>	
Attending or Representative of Primary Team <i>(Required)</i>	
Primary Nurse <i>(Required)</i>	
AC/AOC <i>(Required)</i>	
VUPD <i>(Optional 3/Required 4)</i>	
Social Work <i>(Optional)</i>	
Other:	
Other:	

1. Describe Incident: SBAR <i>(Action or Behavior Exhibited; Persons Involved)</i>				
2. What De-Escalation techniques were used?	Verbal Warning/apology <input type="checkbox"/> Contacted Behavioral SW <input type="checkbox"/> VUPD Notified <input type="checkbox"/> Psychiatric Consult <input type="checkbox"/>			
3. What interventions were initiated?	Medication <input type="checkbox"/> Restraints applied <input type="checkbox"/> 1:1 Observation/Sitter <input type="checkbox"/> Other: _____			
4. Plan/Tactic Owner:	Tactic	Owner	Tactic	Owner
	Notes:			

Timeline for Follow-Up _____