De-escalation Techniques in Acute Care Settings

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Objectives

1. Understand the principles of de-escalation: Define de-escalation and explain its importance in acute care settings, recognize the key principles that underpin effective de-escalation strategies/techniques.

2. Identify early warning signs of escalation: Identify and assess early warning signs of patient agitation and escalation enabling timely and appropriate interventions

3. Apply effective communication techniques: Develop skills in utilizing verbal and non-verbal communication techniques that promote a calming influence and reduce the likelihood of escalation in acute care settings

4. Implement de-escalation strategies in practice: Demonstrate the ability to implement specific de-escalation techniques through shared scenarios, ensuring they can handle real-life situations in acute care settings.

Definitions

De-escalation: A set of methods and actions used to reduce the severity of a conflict, agitated behavior, or potentially violent situation. It's the opposite of escalation

Acute care: A level of health care in which a patient is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery.

Therefore…

- We will focus on REPEATABLE and TEACHABLE strategies* for use in acute care settings to mediate episodic changes in mood or cognition that creates distress or agitation causing:
  - Interruption in care
  - Difficulty with disposition planning
  - Safety issues for patients and staff*

Agitation

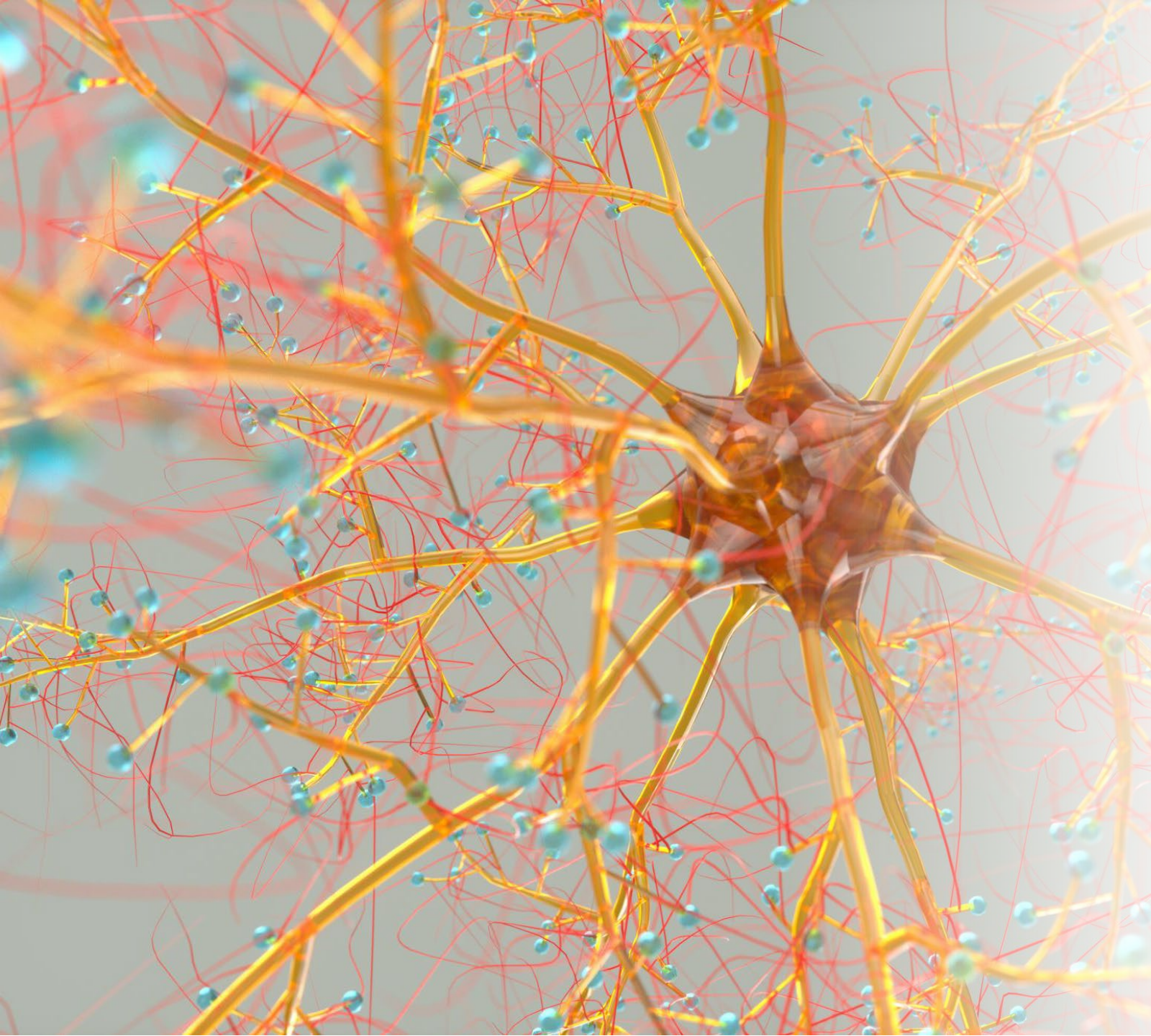
- There is no consensus on definition
- Most definitions denote distress that is atypical or an excess of behaviors (motor or verbal) which interfere with patient care, pose a risk to persons or property, or require action from staff
- Various types:
  - Includes some combination of aggression (verbal or physical), explosive anger, restlessness, disinhibition, akathisia, inappropriate vocalizing, and emotional lability
- Diagnostic Criteria:
  - Behaviors must be present in the absence of other physical, medical or psychiatric causes
  - This person is NOT in control of their emotions or behavior
  - The behavior is UNINTENTIONAL

Common Presentations

When agitation is more likely to occur

Traumatic Brain Injury*

Up to 80% patients experience agitated behavior	Physical aggression	Inappropriate behavior or speech	Sexual comments, cursing, racial slurs
Restlessness	Mood lability	Resolution varies but can persist during the first two to four weeks post injury	Occurs due to disorientation, confusion, and other TBI sequalae



Neuropathology

- Multifactorial
  - Cerebral structural lesions, biochemical abnormalities
- Areas of injury
  - Damage to:
    - Frontal lobe
    - Temporal lobe
    - Limbic System
- Interruption of typical neurotransmitter activity
  - Serotonin, Norepinephrine, Dopamine
  - Moderating behavior

Risk factors

- Age
- Gender
- Mental Health History
- Substance Use History

Delirium

- Delirium is an abrupt alteration in mental abilities.
- Causes disorientation, confusion, loss of awareness
- Onset can be quick – within a few hours or days
- Symptoms also include reduced awareness of surroundings, poor thinking skills, and behavior and emotional changes including delusions and hallucinations
- Causes are typically related to traumatic injury, prolonged hospitalization, metabolic imbalance, medication reactions, infection, surgery, or alcohol or drug use or withdrawal.
- More common in older adults and person diagnosed with dementia, Parkinson's disease, or past episodes
- Treatment involves addressing the causal agent
- **Types of delirium**
  - **Hyperactive delirium:** Patients have increased restlessness, anxiety, rapid mood swings, and visual hallucinations resulting in resistance to care.
  - **Hypoactive delirium:** Patients have reduced activity, are somnolent, and sleep is increased. They stop interacting with staff and family.
  - **Mixed delirium:** Combination of hyper and hypoactive types that fluctuate.

Dementia

- Dementia is a general term for loss of thinking abilities that interfere with independent activity in daily life.
- Also known as MNCD
- Different types: Alzheimer’s = most common
- Increases risk of delirium
- Progressive
- Treatment can moderate changes, but progression is inevitable

Serious Mental Illness

- Depression
- Schizophrenia
- Bipolar disorder
- Increased risk for acute psychosis
- Causes after acute hospitalization
  - Medication adherence
  - Interruptions due to medications
  - Comorbid substance use disorders
  - Other external factors*

Determining Etiology of Agitation

Likely Psychiatric Etiology	Likely Organic Etiology
Oriented	Disoriented
Alert	Depressed Level of Consciousness
Gradual Onset	Sudden Onset
Psychiatric History	No Psychiatric History
Normal Vital Signs	Abnormal Vital Signs
Normal Physical Exam	Abnormal Physical Exam
Age <40 Years	Age >40 Years (Without Psychiatric History)
Auditory Hallucinations	Visual Hallucinations
Flat Affect	Mood Lability
Able to Redirect	Unable to Redirect

Early Warning Signs

- Decreased compliance
- Increased restlessness
- Pacing or other excessive movement
- Impatience
- Pressured speech
- Increased volume of speech
- Angry outbursts
- Anxiety
- Disordered mood
- Changes in vital sings such as tachycardia and hypertension

Best Practice

Agitation Management

Current Practice Standards*

- Non-pharmacological interventions*
  - Verbal de-escalation
  - Diversionary activities
  - Environmental strategies
  - Consistently implemented by ALL staff
- Avoid invasive measures that
  - Cause injury
  - Cause trauma
  - Negatively impacts patient and provider relationships
- Balance patient care while also prioritizing patient dignity and rights to make informed care decisions
- A 2016 study found that approximately 53% of patients experienced de-escalation during initial hospitalization
  - Many experienced multiple episodes (37%)
  - De-escalation was successful in 60% of cases.
  - Successful de-escalations resulted in fewer follow-up episodes of agitation
    - Subsequent episodes were less challenging to control

Importance of De-escalation

Necessary technique

- Prioritize patient safety, dignity, and autonomy
- Prioritizes staff safety
- Decreases interruption in care
- Reduces need for physical or chemical restraint
- Is repeatable, teachable skills that emphasizes patient autonomy

Without de-escalation

- Complicated care
- Injury
- Decreased patient satisfaction
- Can impact patient outcomes
- Prolonged hospitalization

Consider

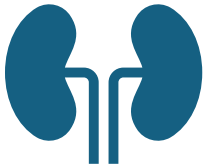
- Implementing annual trainings with certifications
- An assessment model
- Using an interdiciplinary approach
- Protocols for any agitated patient

Key Principles

- Accurate diagnosis of agitation
- Notifying all staff
- Working with Staff/Patient to identify causes
- Consistent and Repeated assessment
- Implementing best practices
- Reserving most restrictive practices
- Use Trauma Informed Care practices

Diagnosis and Secondary Conditions

Obtain HPI, medical comorbidities, and in-depth social history



Perform a comprehensive physical

Vital signs, neurologic exam, cardiopulmonary evaluation, and musculoskeletal exam

Diagnose and treat secondary contributors to agitation

Pain

Aphasia

Medication side effects

Nausea, constipation

Urinary retention, incontinence

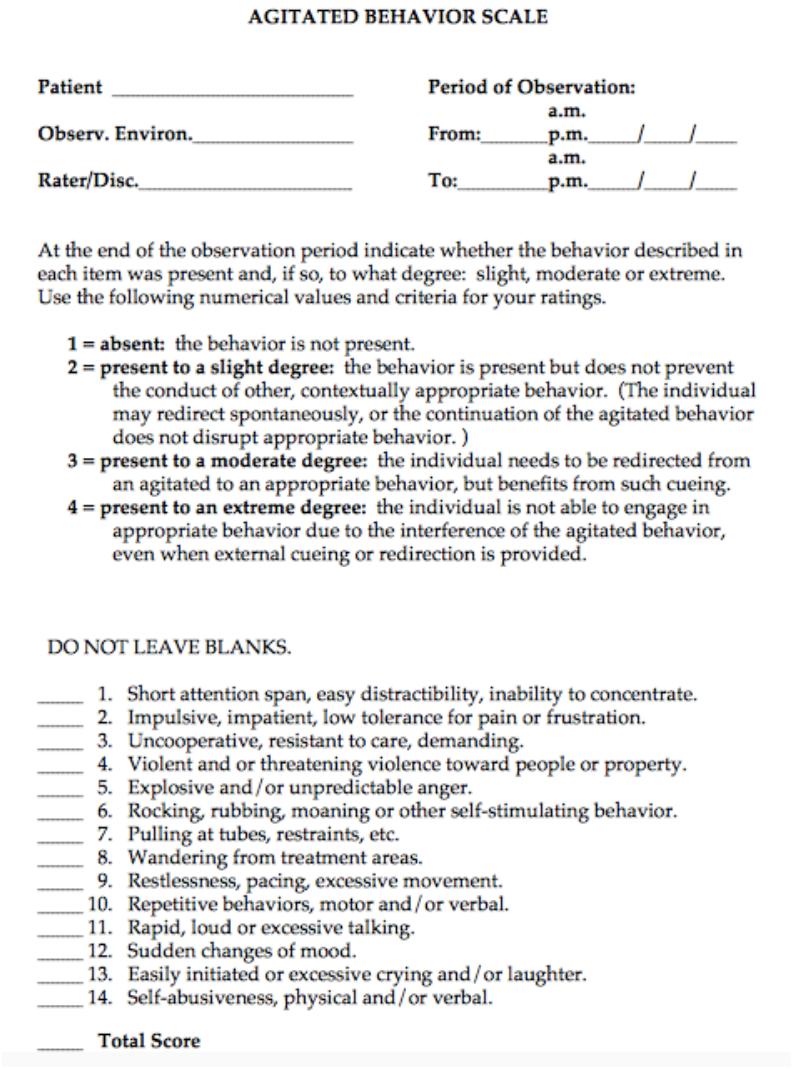
Withdrawal

Depression

NPO and PO restrictions and frustrations

Assessing Agitation

- Best practice recommends standardized measures to objectively assess patients for agitation
- Select assessments that multiple health care professionals can use
- Consider assessing for patterns and response to best practices
- Agitated Behavior Scale
- Brief Risk Assessment tool
- Targeted Risk Assessment
- Measures of Orientation
  - GOAT or OLOG
  - Recovery outcomes associated with PTA



AGITATED BEHAVIOR SCALE

Patient _____ **Period of Observation:**

Observ. Environ._____ **From:**_____ a.m./p.m. ____/____/____

Rater/Disc._____ **To:**_____ a.m./p.m. ____/____/____

At the end of the observation period indicate whether the behavior described in each item was present and, if so, to what degree: slight, moderate or extreme. Use the following numerical values and criteria for your ratings.

1 = absent: the behavior is not present.
2 = present to a slight degree: the behavior is present but does not prevent the conduct of other, contextually appropriate behavior. (The individual may redirect spontaneously, or the continuation of the agitated behavior does not disrupt appropriate behavior.)
3 = present to a moderate degree: the individual needs to be redirected from an agitated to an appropriate behavior, but benefits from such cueing.
4 = present to an extreme degree: the individual is not able to engage in appropriate behavior due to the interference of the agitated behavior, even when external cueing or redirection is provided.

DO NOT LEAVE BLANKS.

____ 1. Short attention span, easy distractibility, inability to concentrate.
____ 2. Impulsive, impatient, low tolerance for pain or frustration.
____ 3. Uncooperative, resistant to care, demanding.
____ 4. Violent and or threatening violence toward people or property.
____ 5. Explosive and/or unpredictable anger.
____ 6. Rocking, rubbing, moaning or other self-stimulating behavior.
____ 7. Pulling at tubes, restraints, etc.
____ 8. Wandering from treatment areas.
____ 9. Restlessness, pacing, excessive movement.
____ 10. Repetitive behaviors, motor and/or verbal.
____ 11. Rapid, loud or excessive talking.
____ 12. Sudden changes of mood.
____ 13. Easily initiated or excessive crying and/or laughter.
____ 14. Self-abusiveness, physical and/or verbal.

____ **Total Score**

De-Escalation 101

Verbal strategies and valuable environmental management

Verbal De-escalation

- Monitor body language
  - Always enter a room with a non-threatening stance
  - Consider personal space
- Introduce yourself and your role
- Clearly express the purpose of the interaction
- Query concerns, frustrations, distress with genuine curiosity
- Slow pace and volume of speech
- Speak in simple terms
- Make supportive statements regarding feelings
- Ask open-ended questions
- Be empathetic
- Avoid judgement

Important Considerations

- Understand that if a patient makes threating or offensive comments; they are not intentional; these are a **symptom**
  - Try to ignore these statements
  - If directed at you; say “that is not appropriate” and move on
- Do not try to reason or argue
- Note and avoid triggers
- Inform before any action
- Model calm
- Encourage eye contact
- Validate patient fears/concerns – inform – move on
- If yelling or angry; let the patient know that you hear that they are “x,” redirect their behavior, provide options
- Reduce physical touch whenever possible
- Limit number of staff in room to 2 whenever possible
- Assign a “point” person to speak
- Don’t have conversations in the room around the patient
- **If your patient is already physically attacking staff; restrain appropriately**

Environmental Management

. Limit confusion

- Routine (day vs. night)
- Revolving staff
- Clear introductions to people and tasks
- Consistency in expectations

2. Communicate clearly

- Use simple language
  - Single step requests
  - Avoid commanding or bargaining

3. Balance stimulation

- Avoid boredom while also…
- Limit visitors and external stimuli
- Prioritize rest after therapies
- Create a schedule

4. Redirect

- Reorient the patient to their surroundings
- Remind the patient that care can help assist in their recovery
- Aid in relearning
- Ask what is needed

5. Prioritize safety

- Assign a sitter
- Padded restraints
- Use your team; if you or the patient are at risk, contact the attending on staff

Identify and Manage Triggers

Patient Related:

- Pain
- Discomfort
- Fatigue
- Hunger
- Incontinence
- Reduced Autonomy
- Reduced locus of control
- Interruptions in sleep-wake cycle (Consider sleep protocols)
- Rest breaks during therapies (Consider co-treatment)
- Monitor and treat anxiety/depression
- Treat pre-existing conditions

Environmental triggers:

- Limit overstimulation
- Manage noise levels
- Monitor number of visitors and use of personal technology
- Reduce confusion (consider re-orientation, education, and congitive rehabilitation)
- Interpersonal Relationships
- Consider possible medication side-effects
- Visual signboards
- And if you can't figure out the trigger…it might be you

Dos and Donts

Do:

Intervene early

Offer options

Summarize the interaction

Reflect feelings

Use least restrictive environment

Work as a team

Don’t:

Get upset

Tell someone to calm down

Box them in to a small space

Enter the room with 17 other people

Forget about your body language

Forget about the patient's body language

Medication*

- Avoid prolonged sedation
- Before medicating consider:
- Are they aggressive or just restless?
- What is the specific unwanted behavior?
- Are you just treating the staff ?

Supporting family

- Families have a big impact on agitation management
- Provide medical history which helps identify risk and help treat conditions that could be triggers
- Provide patients with support and care
- Monitor agitation and identify new triggers
- Beware of family as a trigger or unsafe situations
    - Education helps decrease family distress and promote patient safety
    - Ensure consistency of restrictions

Support Your Team

- Provide training and other resources
- Rotate schedules
- Know the signs of burnout
- EAP programs
- KEY: Remember the environment

Scenarios

Common Scenarios in Acute Care

Case 1

- 36-year-old White male, arrived at ED via EMS following unhelmeted MCC with GCS 8. Imaging revealed bilateral frontal damage.
- The patient was initially unconscious during his admission and physically aggravated upon initial waking in the hospital (e.g., kicking staff and yelling).
- The patient was initially restrained before our team was consulted. Upon our arrival patient was disoriented, confused, and pulling at restraints.
- Subsequent assessment revealed patient was significantly more aggressive when confused/somnolent and when waking up.

Case 2

- 65yr AA Male who was initially brought in following assault with LOC. On admission, GCS 12 and a SDH was found on CT, further his initial examination revealed multiple broken ribs.
- During his first few days of admission, the patient was paranoid of staff, throwing his tray/water, and making verbally aggressive comments to staff and others.
- As his admission continued, he began to evidence increased psychomotor agitation and refusal to participate in treatment.
- Patient was initially restrained, which increased agitation and withdrawal of communication.

Summary

- Remember that emotional regulation is a privilege
- **Consider helping the patient regain control vs. controlling the patient**
- Priority number 1 is safety
- Use trauma informed care
- Monitor risk
- Engage environmental management strategies
- Understand why agitation is happening
- Use first line de-escalation before other restraints
- When in doubt – consider how you would like to be treated

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