

De-escalation in health care

Issue:

The need for using de-escalation techniques has become more prevalent as violence in health care settings increases. De-escalation is a first-line response to potential violence and aggression in health care settings.¹ The Centers for Disease Control and Prevention (CDC) has noted a rise in workplace violence, with the greatest increases of violence occurring against nurses and nursing assistants.² A three-year study in the *American Journal of Nursing* noted that 25 percent of nurses reported being assaulted by patients or the patient's family members. Statistically, higher rates of health care violence are reported to occur in the emergency department (ED), geriatric and psychiatric settings.²

The purpose of this Quick Safety is to present some de-escalation models¹ and interventions for managing aggressive and agitated patients in the ED and inpatient settings. There are many different de-escalation techniques; this Quick Safety is intended to guide health care professionals to resources for more information and training.

It should be noted that there is little research about the efficacy of de-escalation, and there is no guidance of what constitutes the gold standard for practice.¹ A Cochrane review acknowledges that this leaves nurses to contend with conflicting advice and theories regarding de-escalation.³ However, some de-escalation studies have concluded that the positive consequences of de-escalation include:¹

- Preventing violent behavior
- Avoiding the use of restraint
- Reducing patient anger and frustration
- Maintaining the safety of staff and patients
- Improving staff-patient connections
- Enabling patients to manage their own emotions and to regain personal control
- Helping patients to develop feelings of hope, security and self-acceptance

What is de-escalation and what is its purpose?

The literature has several definitions of de-escalation^{1,3} and uses other terms for de-escalation, including conflict resolution, conflict management, crisis resolution, talk down, and defusing.¹ For the purposes of this Quick Safety, we describe de-escalation as a combination of strategies, techniques, and methods intended to reduce a patient's agitation and aggression. These can include communication, self-regulation, assessment, actions, and safety maintenance in order to reduce the risk of harm to patients and caregivers as well as the use of restraints or seclusion. (See the sidebar for an example of using de-escalation.)

Injuries to patients and staff can occur during the use of restraints. Data from the Cochrane Library reveals that in the United States, 40 percent of restraint-related deaths were caused by unintended asphyxiation during restraint.³ The use of restraint and seclusion creates a negative response to the situation that can be humiliating to the patient, and physically and emotionally traumatizing to staff involved.³ Also, it impacts the trust between the patient and health care professionals. Restraint and seclusion should be a last resort, used after other interventions have been unsuccessful, and done to protect the patient, staff and other patients in the area from physical injury.

Example of using de-escalation

A psychiatric unit nurse recounts how he intervened in a power struggle between a patient and an inexperienced nurse and elicited the story from the patient:⁸

"I went into the patient's room and he was very agitated. I asked him if I could sit down and talk to him a few minutes, just to see what was going on with him. I found out during the interaction with the patient that one of the things that had escalated him was that he was threatened. He was told that he would get an intramuscular (IM) injection of medication. And I found out that he was very afraid of needles and so that upset him even more. And, if we had attempted to give him an IM, he was going to fight us tooth-and-nail."

Abridged from: Johnson ME & Hauser PM. "The practices of expert psychiatric nurses: Accompanying the patient to a calmer personal space." *Issues Ment Health Nurs* 22, no. 7 (2001): 651-668.



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Recognizing the aggressive patient

In the mental health setting, dealing with aggressive patients can be an everyday occurrence.³ Acute inpatient psychiatric settings may have patients who exhibit risk-prone behaviors, such as verbal aggression, attempts to elope, self-harming behaviors, refusing to eat or drink, and displaying aggression to objects or people.⁴ The ED has its own set of challenges. Patients come to the ED with hallucinations, hearing voices, or they may be under the influence of unknown substances. Upon entry, a triage nurse must assess the patient.

A number of assessment tools are available to help health care professionals recognize the aggressive patient, including:

- STAMP (Staring, Tone and volume of voice, Anxiety, Mumbling, and Pacing) is a validated tool for use in the ED.⁵
- Overt Aggression Scale (OAS) is a reliable tool for use in the inpatient setting for children and adults.⁶
- Broset Violence Checklist (BVC) has been validated for use in the adult inpatient psychiatric unit.⁵
- Brief Rating of Aggression by Children and Adolescents (BRACHA) has been found to be a valid tool for use in the ED to determine the best placement on an inpatient psychiatric unit.⁶

De-escalation models

The following cyclical de-escalation models from the literature advocate considerable flexibility in the use of different skills and interventions:

- The **Dix and Page** model consists of three interdependent components: assessment, communication and tactics (ACT). Each should be continuously revisited by the de-escalator during the incident.¹
- Similar to Dix and Page, the **Turnbull, et al.** model additionally describes how the de-escalator evaluates the aggressor's response to their use of de-escalation skills by constantly monitoring and evaluating feedback from the aggressor. The authors stress that flexibility in individual cases is more important than basing de-escalation on a few well practiced skills, or using those skills in a pre-determined order, since what may be de-escalatory for one person may be inflammatory for another.¹
- A linear model is the **Safewards Model**, which begins with delimiting the situation by moving the patient or other patients to a safe area and maintaining a safe distance; clarifying the reasons for the anger using effective communication; and resolving the problem by finding a mutually agreeable solution. The model stems from a randomized control trial conducted in the United Kingdom to look at actions that threaten safety and how staff can act to avoid or minimize harm. The trial concluded that simplistic interventions that improve staff relationships with patients increase safety and reduce harm to both patients and staff.⁴

Interventions for defusing aggression

The following interventions can be used to defuse an aggressive situation in both the ED and inpatient psychiatric setting:^{3,5}

- Utilize verbal communication techniques that are clear and calm. Staff attitudes must be non-confrontational in use of verbiage. Avoid using abbreviations or health care terms.
- Use non-threatening body language when approaching the patient.
- Approach the patient with respect, being supportive of their issues and problems.
- Use risk assessment tools for early detection and intervention.
- Staff attitudes, knowledge and skill in using de-escalation techniques must be practiced and discussed in an educational format.
- Respond to the patient's expressed problems or conditions. This will help create a sense of trust with the health care professional.
- Set clear limits for patients to follow.
- Implement environmental controls, such as minimizing lighting, noise and loud conversations.

On inpatient behavioral health units, there are three approaches that can be used to decrease aggression throughout the unit, using a multidimensional aggression assessment process:⁷

- **Patient-centered care approach:** Each patient should undergo a medical exam to rule out any underlying disease or condition; a nursing history and social history should be obtained; an aggression assessment should be conducted using a valid or reliable tool; and a psychiatric evaluation should be completed, including observation for cues or signals of approaching anxiety or aggression.



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- **Staffing-centered approach:** Therapists and staff have training, skills, knowledge and competencies in appropriate areas, including de-escalation. Staff and therapist approach patients with respect, and are non-controlling, unprovocative, non-confrontational, and non-coercive. Staff have very good interpersonal skills.
- **Environmental-centered approach:** Diversionary activities should be available at all times. The physical layout should allow patients to move about freely, without feeling cramped, and provide for personal space. Apply consistent unit rules to every patient. Avoid loud conversations and additional noise whenever possible. Maintain a small census and shorter length of stay whenever possible.

The 10 interventions to reduce conflict and minimize harm of the Safewards Model are:

1. Mutually agreed upon and publicized standards of behavior by and for patients and staff. Patients and staff meet as a group to discuss these expectations for behaviors while on the unit.
2. Short advisory statements (called soft words) to be used during flashpoints, hung in the nursing office and changed every few days.
3. A de-escalation model used by best de-escalator on the staff (as elected by the ward concerned) to increase the skills of others on the ward.
4. A requirement to say something good about each patient at nursing shift handover.
5. Scanning for potential bad news a patient might receive from friends, relatives or staff, and intervening promptly to talk it through.
6. Structured, shared innocuous personal information between staff and patients (such as, music preferences, favorite films, and sports) via a 'know each other' folder kept in the day room.
7. A regular patient meeting to bolster, formalize and intensify interpatient support.
8. A crate of distraction and sensory tools to use with agitated patients (for example, stress toys, mp3 players with soothing music, light displays, textured blankets).
9. Reassuring explanations to all patients following potentially frightening incidents.
10. A display of positive messages about the ward from discharged patients.

Safety actions to consider:

There are a number of actions that health care organizations can take to make sure that staff is prepared to intervene and de-escalate a potentially dangerous or harmful situation should a patient become aggressive or agitated. The following strategies are derived from the Safewards Model:⁴

- Commitment by senior management to change. Leadership must endorse resources needed to educate staff, and allow time to audit the interventions and environmental changes needed to create the most therapeutic unit possible.
- Use audits to inform practice. The Patient Staff Conflict Checklist (PCC)⁴ is an example of a reliable and valid tool. At the end of each shift, the charge nurse records the number of times conflicts (actions that threaten safety) and containments (restraint, seclusion or observation) occurred — not the number of patients involved.
- Implement workforce training on new techniques and interventions.
- Incorporate the use of assessment tools.
- Involve patients.
- Use debriefing techniques.

Should violence occur despite efforts to de-escalate the situation, organizations should be prepared to address workplace violence issues, as described in Sentinel Event Alert 59, “Physical and verbal violence against health care workers.”⁹ The alert provides suggested actions, including:

- Clearly defining workplace violence and putting systems in place across the organization that enable staff to report workplace violence instances, including verbal abuse.
- Recognizing that data come from several sources, capture, track and trend all reports of workplace violence—including verbal abuse and attempted assaults when no harm occurred, but in which the health care worker feels unsafe.
- Providing appropriate follow-up and support to victims, witnesses and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary.
- Reviewing each case of workplace violence to determine contributing factors. Analyzing data related to workplace violence, and worksite conditions, to determine priority situations for interventions.
- Developing quality improvement initiatives to reduce incidents of workplace violence.

- Training all staff, including security, in de-escalation, self-defense and response to emergency codes.
- Evaluating workplace violence reduction initiatives.

Resources:

1. Hallet N and Dickens GL. “De-escalation of Aggressive Behaviour in Healthcare Settings: Concept Analysis.” *IJNS* 75 (2017):10-20.
2. Brous E. “Workplace Violence: How It Affects Health Care, Which Providers Are Most Affected, and What Management and Staff Can Do About It.” *AJN* 118, no. 10 (Oct 2018):51-55.
3. Du M, et al. “De-escalation techniques for psychosis-induced aggression or agitation (Review).” *Cochrane Database of Systematic Reviews* 2017, Issue 4. Art No.: CD009922.
4. Bowers L, et al. “Reducing Conflict and Containment Rates on Acute Psychiatric Wards: The Safewards Cluster Randomised Controlled Trial.” *Int J Nurs Stud* 52 (2015): 1412-1422.
5. Calow N, et al. “Literature Synthesis: Patient Aggression Risk Assessment Tools in the Emergency Department.” *J Emerg Nurs* 42, no. 1 (Jan 2016): 19-24.
6. Barzman DH, et al. “Brief rating of aggression by children and adolescents (BRACHA): Development of a tool for assessing risk of inpatients’ aggressive behavior.” *J Am Acad Psychiatry Law* 39 (2011): 170-9.
7. Gardner LA & Magee MC. “Patient-to-patient aggression in the inpatient behavioral health setting.” 11, No. 3 (2014): 115-123.
8. Johnson ME & Hauser PM. “The practices of expert psychiatric nurses: Accompanying the patient to a calmer personal space.” *Issues Ment Health Nurs* 22, no. 7 (2001): 651-668.
9. The Joint Commission. “[Physical and verbal violence against health care workers.](#)” Sentinel Event Alert 57 (2018).

Note: This is not an all-inclusive list.

Other resources:

- Hallet N and Dickens GL. “De-escalation of Aggressive Behaviour in Healthcare Settings: Concept Analysis.” *IJNS* 75 (2017):10-20. Article includes a table of the attributes of de-escalation in the five areas of communication, self-regulation, assessment, actions, and maintaining safety.
- Johnson ME & Hauser PM. “The practices of expert psychiatric nurses: Accompanying the patient to a calmer personal space.” *Issues Ment Health Nurs* 22, no. 7 (2001): 651-668. This interpretive phenomenological study includes several real-life examples of using de-escalation techniques.
- Mavandadi V, et al. “Effective Ingredients of Verbal De-escalation: Validating an English Modified Version of the ‘De-escalating Aggressive Behaviour Scale.’” *J Psychiatr Nurs Ment Health Serv* 23 (2016): 357-368.
- Gaynes BN, et al. “Preventing and De-escalating Aggressive Behavior Among Adult Psychiatric Patients: A Systematic Review of the Evidence.” *Psychiatr Serv* 68 (2017): 819-831.

Workplace Violence Resources:

The Joint Commission

- “[Physical and verbal violence against health care workers.](#)” Sentinel Event Alert 57 (2018)⁹
- [Workplace Violence Prevention Resources](#)
- [Questions & Answers: Hospital Accreditation Standards & Workplace Violence](#)
- [Improving Patient and Worker Safety](#) (Pages 95-108)²⁷

Occupational Safety and Health Administration (OSHA)

- [Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers](#)
- [Preventing Workplace Violence in Healthcare](#)

Centers for Disease Control and Prevention (CDC)

- [Workplace Violence Prevention for Nurses](#)
- [Home Healthcare Workers: How to Prevent Violence on the Job](#)

Centers for Medicare and Medicaid Services (CMS)

- [Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers](#)



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