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AN EVIDENCE-BASED INTERVENTION TO REDUCE THE USE OF PHYSICAL
RESTRAINTS IN A FEMALE ADOLESCENT POPULATION
AT AN INPATIENT PSYCHIATRIC UNIT

by

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GOD BLESS YOU ALL.

Mambo Ndingwan

TABLE OF CONTENTS

STATEMENT OF THE PROBLEM	6
Background and Significance	7
ASSESSMENT	8
Needs Assessment.....	11
Organization’s Readiness for Change and Stakeholder Engagement.....	12
PROJECT IDENTIFICATION.....	13
Purpose.....	13
Objectives	13
SUMMARY AND STRENGTH OF THE EVIDENCE	14
METHODS	16
Project Intervention.....	16
Organizational Barriers and Facilitators	20
Ethical Considerations	21
RESULTS	22
DISCUSSION.....	23
LIMITATIONS.....	24
RECOMMENDATIONS	25
IMPLICATIONS FOR PRACTICE	25
REFERENCES	27

Table of Contents—Continued

APPENDICES	31
Appendix A: Figure 1. Patients Assessed Versus Month	31
Appendix B: Figure 2. Number of Physical Restraints per Month.....	32
Appendix C: The Modified Over Aggression Scale (MOAS) Handout	33
Appendix D: Debrief Handout.....	37
Appendix E: Verbal De-escalation Training Session Attendance Register.....	39
Appendix F: Pre/Post Test Survey for Verbal De-escalation Training.....	40
Appendix G: PowerPoint Presentation	32
Appendix H: Letter of Support	33

Abstract

The use of physical restraints within psychiatric units is problematic since it raises a range of legal, ethical, and clinical questions (American Psychiatric Nurses Association, 2014). The use of physical restraint has become a common practice in many psychiatric units despite the negative effects associated with its use. Selecting strategies such as verbal de-escalation to manage aggressive psychiatric inpatients shows promise with patients when used by providers and staff in mental health facilities. The purpose of this evidence-based project was to introduce and train staff to utilize the Modified Overt Aggression Scale (MOAS) and verbal de-escalation in psychiatric units in a residential psychiatric treatment center with aggressive female inpatients aged 13 to 17 years old. The primary objectives were to reduce the selection of physical restraints and time used to restraint to less than an hour, assess 100% of the target population, educate providers/staff the use of MOAS and verbal de-escalation, and review intervention choices selected by staff. The intervention included implementing MOAS scale, training staff to use verbal de-escalation, and pre- and post-test surveys to evaluate the effectiveness of verbal de-escalation techniques. Between January and April 2019, 20 patients met the inclusion criteria. Following the intervention, documented physical restraints decreased by 89%, time spent in restraints decreased to 10 minutes, 100% of the staff was trained, 18 patients were assessed, and 18 intervention choices were reviewed. Results suggest that a combination of MOAS scale along with staff training on verbal de-escalation can influence and reduce the selection of physical restraints in the inpatient psychiatric unit.

Keywords: physical restraints, verbal de-escalation, training, aggression.

According to Hadi, Khosravi, Shariat, and Nadoushan (2015), physical restraint is a powerful intervention that is often used in mental health facilities. The primary objective of using physical restraint in a psychiatric unit is to protect patients from harming themselves or others. Therefore, the use of physical restraints is inevitable in some situations, even though it is highly disputed. Hadi et al. found that the use of physical restraint might lead to complications and problems for both patients and staff. Additionally, physical restraints may decrease positive behavior, whereas escalating negative behavior among mental health patients (Darwin, McGowan, & Edozien, 2013). In the most extreme cases, physical restraint may cause death for some patients (Hadi et al, 2015). It is, therefore, desirable to reduce the use of physical restraint to the minimum as possible. Hadi et al. suggests that it is possible to prevent approximately 75% of physical restraints through the implementation of appropriate interventions such as determining factors that lead to aggression and training providers and staff how to perform de-escalating techniques. According to Margari et al. (2005), the Modified Overt Aggressive Scale (MOAS) plays a significant role in measuring several types of aggressive behaviors including verbal aggression, aggression against properties, auto-aggression, and physical aggression, observed over the past week. Introducing the MOAS tool and evidence-based verbal de-escalation techniques in a psychiatric unit provides the best intervention to reduce the selection of physical restraints.

Statement of the Problem

In the United States, many psychiatric units continue using physical restraints despite potential negative effects associated with the use of this intervention (Masters, 2017). According to Vedana et al. (2018), patients in mental health facilities often experience physical restraints as coercion and trauma, and this affects nurse-patient relations. To reduce excessive use and

selection of physical restraints and its associated risks, providers and staff in the psychiatric unit need to familiarize themselves with the MOAS tool to predict and assess aggressive behavior together with the application of verbal de-escalation technique.

Background and Significance

Approximately 10% to 20% of individuals with mental health disorders engage in challenging behaviors such as aggressiveness, destructiveness, and self-injurious actions (Volavka, 2014). These aggressive behaviors, especially in psychiatric units, push providers and staff to utilize physical restraints as an intervention strategy to manage aggressive patients.

Moreover, providers and staff often use physical restraints to protect and prevent harm to aggressive patients as well as prevent them from harming others (Garriga et al., 2016). The excessive and unnecessary use of physical restraints creates potential danger and even becomes fatal to the patients (Joint Commission, 2016).

It is important to perform an individual assessment of each patient to determine whether alternative interventions exist, such as verbal de-escalation, before implementing physical restraints. Most psychiatrists will utilize physical restraints when patients are aggressive and threaten to harm themselves or other individuals (Masters, 2017).

According to Huang et al., 2009, the MOAS is an inpatient rating scale that assesses four categories: verbal aggression, aggression against property, auto aggression and physical aggression. For each category of aggressive behaviors, the rater checks the highest applicable rating point to describe the most serious act of aggression during the specified observation period. Each is weighted using a psychometrically validated method developed by the MOAS authors. According to Margari et al. (2005), the MOAS scale has good psychometric properties. Patient assessment is essential since it helps to identify risk factors, as well as promote best

intervention practices, by providers and staff that minimize adverse events, such as staff injury by the patient, patient seclusion, and restraint usage (Sands, Elson, Gerdtz, & Khaw, 2012). According to Griffith et al. (2016), employing the MOAS in psychiatric units supports the caregivers to assist in implementing appropriate interventions to patients who are likely to become aggressive, preempting this behavior to prevent excessive use of potentially harmful physical restraints that can negatively impact patients' well-being. In addition to the MOAS, the ten domains of the de-escalation strategies by the American Association for Emergency Psychiatry (AAEP) using their determined Best practices in Evaluation and Treatment of Agitation (Project BETA) de-escalation workgroup were utilized. The domains of de-escalation listed the following: Respect Personal Space, Do not be Provocative, Establish verbal contact, be concise, Establish wants and feelings, Listen closely to what the patient is saying, agree or agree to disagree, Lay down the Law and set clear limits, offer choices and optimism and debrief the patient and staff (Richmond et al., 2012).

Assessment

The residential psychiatric treatment center assessed in the project is in a metropolitan area in central Texas within the 76708 zip code. Demographic data available from the Census Bureau shows that the population in this zip code is approximately 27,172 (TX Hometown Locator, 2018). The median age of the population living in the 76708 zip code is 34.3. The median age of men is about 17.3% smaller than that of women (Town Charts, 2018). The average family size of a typical family in this zip code is three, and 71% of families are a husband and wife family. This zip code contains 10,558 housing units. The median household income is \$47,574, and 81% of the population is high school graduates. There are 563 people per square mile in this zip code, and the community is predominantly White 50.6% and 31.7%

Hispanic (TX Hometown Locator, 2018).

This residential psychiatric treatment center was founded in the year 1919 as a state home for dependent and neglected children. This residential psychiatric treatment center offers services to the entire state of Texas. The services offered include mental health/psychiatric residential treatment to adolescent patients aged 13 to 17 years suffering from severe emotional/behavior disorders and serious dysfunctional family issues. The treatment services offered include psychiatry, nursing, psychotherapy, nutrition, spiritual, habitation, and Texas Education Agency (TEA) approved education services. A report from the hospital administration where the project took place reported that this facility plays a significant role in providing medical nursing and social worker training opportunities to local colleges and universities.

This residential psychiatric treatment center is situated in a large expanse of land, which is approximately 47.19 acres. There are 46 structures that include storage buildings, pavilion, living units, cafeteria, school buildings, administrative offices, auxiliary service buildings, horse barn, two large buildings that are currently out of service, and four structures planned for repurposing. This facility has a total bed capacity of 78 beds. The average length of stay as on September 30, 2018 was 161 days. The average daily census as at August 31, 2018 was 72. Additionally, 100% of the patients are voluntary admissions.

This facility had a budget of \$11,895,000.00 for the fiscal year 2017. The average daily cost of the stay as of September 30, 2018, was \$469.00 while the average cost per patient was \$27,109. The general revenue from the state of Texas, Medicaid, and private third party insurance finances this facility. The last time the Joint Commission accredited this facility was in August 2016, and the next accreditation will be due in August 2019. This facility received patients from 60 different counties within Texas in the fiscal year 2018, which ended August 31,

2018. A report from the hospital administration reported that this facility's admissions come from all counties within Texas with 8.4% being the highest from Tarrant, 6.3% from Bell, 5.6% from Collin, and 4.9% from Dallas. This psychiatric treatment center has six units: two for adolescent females and four for adolescent males. The basic criteria for admission in this center include the fact that patients must be between 13 to 17 years old, psychiatrically diagnosed as emotionally and/or behaviorally disturbed, and a history of behavior adjustment problems. Adolescent patients admitted in this facility must have referrals that come from State Hospitals, Local Mental Health Authorities, a Community Resource Coordination Group, or Child Protective Services.

This facility operates 24 hours a day. The total number of professionals working in this facility includes two psychiatrists with a Medical Doctorate (MD), 10 RNs with an associate degree, four RNs with a BSN degree, 113 psychiatric nursing assistants (PNA), eight Licensed Vocational Nurses (LVNs), six Therapists, and one Family Nurse Practitioner (FNP). This facility has three operating shifts: the day shift from 7:00 a.m. to 3:30 p.m., evening shift from 3:00 p.m. to 11:30 p.m., and the night shift from 11:00 p.m. to 7:30 a.m. During regular business hours, the ratio of patients to PNA is 5:1. The ratio of patient to PNA is 10:1 after regular business operating hours since there are minimal activities during the night because most of the patients are sleeping.

At the time the project took place, the facility had 9 clients aged 13 years, 44 clients aged 14 years, 32 patients aged 15 years, 34 patients aged 16 years, and 24 patients aged 17 years. Whites and Hispanics comprised 77.6 % of the total population of admitted clients, Black/African American 19.6%, Multiracial 2%, and Asian 1%. Male clients added up to 53.2% of the total admitted patients while females added up to 46.8 of total clients' population.

Needs Assessment

A needs assessment helps to identify loopholes, which lead to poor patients outcomes, between current clinical practices and desired results as well as gather information regarding clinical processes and prioritize areas that require improvement (Grant, 2002). Additionally, the needs assessment helps to pinpoint specific clinical processes that affect patient safety and quality care (Grant, 2002). During the microsystem assessment performed in the residential psychiatric center identified a total number of 197 physical restraints used in the fiscal year 2017. A report from the hospital administration where the project took place reported that this facility usually uses restraints before trying other interventions, such as verbal de-escalation thus leading to excessive use of physical restraints. According to Wilsona et al. (2015), it is important to use alternative intervention strategies such as verbal de-escalation first before proceeding to implement physical restraints.

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Organization's Readiness for Change and Stakeholder Engagement

The success of an evidence-based project depends on the assessment of the health facility's readiness to embrace change (Grant, 2002). Engagement of all the providers and staff helps to smoothen the transition as well as maintain the productivity in a given health facility (Rodriguez, Xiao, Martinez, Friedberg, 2016). A culture that promotes collaboration, appreciation, and respect is enhanced through the act of including all providers and staff in the change process (Rodriguez et al., 2016). It is vital for the mental healthcare providers to visualize the improvements that help in improving patients' quality of life even though change in workflow, sometimes, tends to be a hard adjustment. The way providers and staff work together and assist each other during difficult and hectic days play a role in assessing their readiness to change (Rodriguez et al., 2016).

The need for reducing restraints at the facility where the project took place was identified initially by a director in December 2014. An educational program, and adopted training curriculum specifically for all new hires in an effort to reduce physical restraints was implemented as part of an ongoing process. Based on information from a director the educational program seemed to be working slowly. It was believed that the implementation of the MOAS and verbal de-escalation intervention enhanced the current educational program. The facility also encouraged healthcare workers involved in restraints to watch the videos as a teaching tool to continue efforts to minimize restraints. The executive leadership team, the Director, and the resident specialist continued to monitor all restraints on video twice per week. They also agreed that other intervention strategies such as verbal de-escalation training reduced the occurrence of physical restraints.

A pre-test survey was utilized to assess 16 mental healthcare providers to determine the

organization's readiness for change (Appendix F). The pre-test survey listed five questions designed to identify the level of providers' understanding regarding the use of verbal de-escalation. After answering the five pre-test survey questions, results were calculated. All participants strongly agreed that they interact with aggressive patients frequently. On the other hand, the response for pre-test survey question four was "undecided" for all the participants. This result indicated a need for the organization to embrace a new strategy to manage aggressive patients.

Despite the results obtained from the pre-test survey, providers and staff work in harmoniously manner, possess same values and beliefs, and work toward a common purpose and goal to care for the psychiatric inpatients in the facility. This facility comprehends the importance of quality and competent mental healthcare providers and staff ready to embrace implementation of MOAS tool and verbal de-escalation with the aim of reducing physical restraints.

Project Identification

Purpose

The purpose of this evidence based project (EBP) was to reduce physical restraints through the introduction and implementation of the MOAS evidence based assessment tool and verbal de-escalation techniques based on the AAEP Project BETA (Best practices in Evaluation and Treatment of Agitation) De-escalation Workgroup as an intervention within providers and staff in the female adolescents unit of the residential psychiatric center.

Objectives

The objectives of the project were to:

1. Reduce the restraint time to an hour or less based on the national average of 25

minutes by March 2019.

2. Assess 100% of the target population on the unit.
3. Educate 100% of the Providers/staff in the female adolescents' psychiatric unit on the use of the MOAS and verbal de-escalation technique.
4. Review 100% of the intervention selection choices made by nurses as documented in patient charts.

The aims of this EBP were to 1) reduce providers/staff selecting physical restraints as a way to manage patients and 2) increasing verbal de-escalation as an alternative intervention strategies by April 2019. The process began with providers and staffs assessing for aggressiveness in psychiatric patients using the MOAS tool. The process ended with implementation of verbal de-escalation among the aggressive psychiatric inpatients.

Anticipated Outcomes

By utilizing the intervention process, the DNP student expected to increase awareness of MOAS scale and verbal de-escalation to reduce the use of physical restraints. Specific benchmarks for this project included:

1. By April 2019, 100% of the providers and staff in the female adolescents psychiatric unit will be educated on the use of the MOAS evidence based assessment tool and verbal de- escalation intervention. By April 2019, there will be a reduction in the time spent in restraints to an hour or less based on the national average of 25 minutes.
2. By April 2019, 100% of the patients admitted to the unit will be assessed.
3. By April 2019, 100% of the intervention selection choices will be reviewed.

Summary and Strength of the Evidence

According to Foebel et al. (2016), the use of physical restraints interferes with patients'

functional and cognitive ability. Foebel et al. (2016) conducted a retrospective cohort study that aimed to determine the effects of using antipsychotic (AP) medications and physical restraints among patients with psychiatric disorders. The participants of this study included 532 individuals with dementia from 57 nursing homes. Effects of using AP medication and physical restraints were evaluated using a Poisson log regression model for 6 months. Results showed that physical restraint triggered higher risks on a patient's functional and cognitive ability compared to the use of AP medications. Foebel et al. (2016) retrospective cohort study suggests that even though antipsychotic use is cautioned, the use of physical restraint is potentially more risky to residents with psychiatric disorders.

According to Lavelle et al. (2016), de-escalation refers to the use of verbal and non-verbal communication to halt aggression and violence during the escalation phase of a patient's behavior. Lavelle et al. (2016) conducted a retrospective case note analysis to determine factors that influence the use of de-escalation and its success in eliminating violence and aggression in an acute psychiatric inpatient setting. This retrospective case note analysis involved 522 patients, and their involvement in aggression was recorded during the first two weeks of their admission (Lavelle et al., 2016). Lavelle et al. (2016) identified the frequency and order of aggression during each shift and analyzed the sequences of events occurring in shifts involving de-escalation. Sequences, where de-escalation halted aggression pattern, were categorized 'successful,' and the rest categorized as 'unsuccessful.'

More than 53% of the patients experienced de-escalation during the first two weeks of admission and de-escalation was successful in approximately 60% of these cases (Lavelle et al., 2016). According to Lavelle et al. (2016), de-escalation is effective intervention when it comes to reducing aggression in an acute psychiatric inpatient setting. Therefore, providing evidence-

based staff training helps to boost providers and staff confidence in the use of de-escalation technique.

Price, Baker, Bee, and Lovell's (2015) de-escalation technique is a recommended non-physical intervention for managing violent and aggressive patients in mental health facilities. Despite de-escalation techniques been taught as part of mandatory training for all National Health Services (NHS) mental health staff, there lacks clarity regarding training effectiveness. Price et al. conducted a systematic review of the learning, performance, and clinical safety outcomes of de-escalation techniques training. This review process involved a systematic literature search of 20 electronic databases, eligibility screening of results, data extraction, quality appraisal, and data synthesis (Price et al., 2015). According to Price et al., 38 relevant studies were identified and the strongest impact of training appeared on de-escalation-related knowledge, confidence to manage aggression, and de-escalation performance. This systematic review literature search suggests that de-escalation techniques training play a vital role to improve mental health providers and staff's ability to de-escalate violent and aggressive patients as well as improve safety in practice (Price et al., 2015).

Methods

Project Intervention

The project setting was a residential psychiatric treatment center in a metropolitan city within central Texas in the 76708 zip code. The intervention took place in one of the female adolescents unit of the residential psychiatric treatment center. The participants in the study included 20 adolescent female patients between the ages of 13 to 17 years and 16 fulltime providers and staff in this unit.

Considering the time of the training sessions, the Nurse Manager approved the specific

times of training for each of the 16 providers and staff based on the nursing schedule. Three training sessions were held to accommodate the various shifts during the period from January 17th to the 31st. The first week of training emphasized on the MOAS scale while the second week concentrated on verbal de-escalation. In terms of the times that training was to occur, the first session took place at 1:00 p.m. to accommodate the morning shift, the second at 7:00 p.m. for the evening shift providers and staff, and the third at 11:00 p.m., which facilitated the providers and staff on the night shift. Even though the DNP student planned for different training sessions, the schedule did not work as planned. Therefore, the DNP student had to individually teach small groups separately that were available at a particular time. Each training session took 30 minutes. The reason for the three sessions was to give providers and staff from each shift an opportunity to be a part of the program. Additionally, it allowed flexibility and ease of training because it did not create disruption in staffing schedule. These training sessions were only available for providers and staff since they work directly with patients. Furthermore, providers and staff have the obligation to decide the type of intervention to use on aggressive patients. The educational training program included the review of the training handouts, which involved the MOAS scale, verbal de-escalation techniques, and case scenarios. A debriefing was carried out. The DNP student was responsible for developing and designing all the educational training materials required for the EBP. The training materials were developed one month prior to the beginning of the training sessions. The psychologist and psychiatrist at the treatment center reviewed the training materials to ensure compliance and buy in from instrumental stakeholders before using them in the training sessions.

The staffing schedule was reviewed prior to educating providers and staff in using the MOAS assessment tool and verbal de-escalation technique. On January 16th, the DNP student

met the nurse manager to determine the dates that the providers and staff can begin training during the period outlined. Providers and staff were trained during the first week of intervention, January 17th to 31st, based on the schedule.

The training sessions took place in the education room, at the residential psychiatric treatment center, which consisted of a whiteboard, a round table, and 10 chairs to accommodate the participants. The education room was used for training sessions since it was quiet and easily accessible. Even though the DNP student planned for different training sessions, the schedule did not work as planned. Therefore, the DNP student taught small individual groups separately that were available at a particular time. Each training session took 30 minutes. The reason for the three sessions was to give providers and staff from each shift an opportunity to be a part of the program. Additionally, it allowed flexibility and ease of training because it did not create disruption in staffing schedule. These training sessions were only available for providers and staff since they work directly with patients. Furthermore, providers and staff have the obligation to decide the type of intervention to use on aggressive patients. The educational training program included the review of the training handouts, which involved the MOAS scale, verbal de-escalation techniques, and case scenarios. A debriefing was carried out. The DNP student was responsible for developing and designing all the educational training materials required for the EBP. The training materials were developed one month prior to the beginning of the training sessions. The psychologist and psychiatrist at the treatment center reviewed the training materials to ensure compliance and buy in from instrumental stakeholders before using them in the training sessions.

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At the beginning of each training session, the providers and staff signed an attendance register created by the DNP student to keep a record of all attendees (Appendix E). The providers and staff introduced themselves to the presenter and gave some background information regarding their practice and experience working in the outpatient clinic. This brief introduction was done to help the providers and staff feel comfortable to foster a productive learning environment. After the introduction, the DNP student showed the providers and staff a copy of the MOAS scale or verbal de-escalation handout depending on the training week. A red and green binder were provided to the providers and staff. The red binder was for empty assessment forms while the green binder was for completed assessments that were reviewed by the DNP student.

On January 17, 2019, providers and staff were given all the material necessary to understand the MOAS scale and the verbal de-escalation techniques. In the first week of training, the MOAS material was printed and given to the providers and staff (Appendix C). The providers and staff learned how to administer the MOAS scale with patients. In the second week of training, the verbal de-escalation training material was printed and given to the providers and staff. The material focused on determining the common signs of aggression. Additionally, it discussed the aim of using verbal de-escalation techniques in improving patient care.

Assessments using the MOAS scale occurred beginning on February 1 ending April 6 after the first training session. The providers and staff completed MOAS assessment forms every Tuesday, which treatment team meeting occurred, and placed them in a green binder for the DNP

student to review. At the same time, February 1 ending April 6, verbal de-escalation was utilized. A training handout on aggression scenarios was included to assist providers and staff in the application of the technique to an aggression problem experienced by a patient.

Using a similar training approach for this session training sessions allowed providers and staff to be comfortable with the training experience, and have a sense of the format of the sessions and what they were likely to experience during the session.

At the beginning of the verbal de-escalation training session, providers and staff were given a pre-test, survey that assessed their current capacity and proficiency with the verbal de-escalation techniques (Appendix B). Issuing of the pre-test survey was meant to give a synopsis of where each provider and staff stands when it comes to the practice of verbal de-escalation techniques. At the end of the training in verbal de-escalation, providers and staff were given a post-test survey with the same questions as the pre-test. This was done to determine if the providers and staff believed that they have a better understanding of verbal de-escalation techniques after being trained by the DNP student. Debriefing (Appendix D) was done after each training session to raise relevant questions relating to the providers and staff experiences with aggressive patients as well as to remind them of the information they learned during the training.

Organizational Barriers and Facilitators

The organizational barriers for this project included staffing challenges and the small number of staff allocated to the female adolescents unit, was challenging in terms of implementing a new intervention strategy. Some staff was resistant to the introduction of a new screening tool to identify patients at risk for aggressive behavior. With others, a lack of accuracy in documenting information, such as the type of intervention strategy used by staff in the patient chart, occurred.

Facilitators for this project included the ease to use the MOAS assessment tool, which mainly because the MOAS can be easily accessible, free, and relatively simple understand and implement. The MOAS tool is friendly; the parents at home can use it during home visit to track aggression. Less than two hours in training time is expected for MOAS scale assessment and the verbal de-escalation techniques training sessions. The facility administration was very welcoming to the DNP student and was willing to participate.

Ethical Considerations

This study poses minimal risk to participants. While there was direct interaction with patients, the providers and staff were not obligated to complete any actions that were not a part of the regular duties that they perform on a daily basis. There were no disturbances caused because of assessing the patients with the MOAS assessment tool. The documentation of the MOAS aggression score on the patient chart did not differ from the clinic's documentation of including information on patient behaviors. It did not pose a significant risk. The implementation of verbal de-escalation strategies did not pose a significant risk to patients or staff. The intervention did not include the use of medication, devices, or physical interaction. All data was collected from non-invasive sources and stored on a password-protected computer that can only be accessed by the DNP student. Information central to the project was collected. De-identification of subject information was done prior to any reporting.

Data was kept confidential by copies of the patient chart and the completed MOAS checklists containing the patient name and information were kept in a locked file cabinet within the clinic nurse office in the female adolescents unit of the residential psychiatric treatment center. The DNP student alone only accessed contents of the filing cabinet. Any patient information was available to only authorized center staff. Data was recorded after de-

identification into an excel spreadsheet. Any patient forms used to extract data was shredded at the conclusion of this project. The project was monitored routinely for data collection, de-identification, and storage by the psychiatrist and psychologist based at the residential psychiatric treatment center. Individuals at the psychiatric center were not required to sign a consent form for this EBP project. All patient information related to demographics, procedures, diagnoses, providers, and center encounters was identified. Only information relevant to the project was entered into the excel spreadsheet.

The benefits associated with participating in this intervention included a reduction in the use of restraints by nurses and the use of verbal de-escalation strategies, improving clinical outcomes by identifying patients with a tendency for greater aggression and providing verbal de-escalation when necessary. Understanding patient aggression based on MOAS aggression score can help nurses be more aware of patients who are likely to become aggressive, thus allowing for improved patient outcomes.

An application for project approval was submitted on November 12, 2018, to the institutional review board, and approval was received indicating that this project was deemed to “Not Regulated Research” and found not to meet federal regulatory requirements for human subject research and does not require IRB approval.

Results

Between January and April, a total number of 20 patients aged 13 to 17 years were admitted to the female adolescents psychiatric unit, the project site. Out of these 20 teenagers, 18 of them were assessed at least once per week using the project intervention. Two patients were not assessed since they were discharged before the MOAS assessment could be completed (see Fig. 1).

Physical restraints used during the implementation period of the project were $n=2$, $n=1$, and $n=3$ for February, March, and April respectively. The total restraints during this period were $N=6$ with a mean average of two restraints. This number shows a decline in the selection of physical restraints as a method to manage aggressive psychiatric inpatients compared to the monthly number of restraints used before the implementation of the intervention, which was 20, 18, and 19 for October, November, and December 2018 respectively. The total number of restraints documented before the project implementation was $N = 57$ with the median number of restraints for that period was $n=19$. Physical restraints decreased from 19 to 2 over the implementation period, reducing physical restraints by 89%. The objective to reduce the monthly use of physical restraints by 50% because of the introduction of the MOAS tool and implementation of verbal de-escalation was met (see fig. 2) The time spent to restrain, before project implementation, was 50 minutes compared to 10 minutes used during the project implementation. The objective to reduce time spent during restraint was achieved. One-hundred percent of the providers and staff were educated on how to use the MOAS and verbal de-escalation technique. Ninety percent of the patients' chart was reviewed for the use of MOAS and verbal de-escalation technique during the interdisciplinary team meeting.

Discussion

Studies have shown de-escalation to be an effective intervention for reducing aggression in an acute psychiatric inpatient setting (Lavelle et al., 2016). Providers and staff in the project site found the implementation of MOAS tool and verbal de-escalation helpful in reducing the use of physical restraints. After the implementation of this evidence based project, the overall time spent during restraint was no more than 10 minutes thus meeting the project objective to reduce time spent during physical restraint to 25 minutes or less. The current target of physical restraint

use for inpatient psychiatric care is 27 minutes of restraints per 1,000 hours of inpatient psychiatric hospitalization (Masters, 2017).

The MOAS scale enabled the providers and staff to assess and detect aggressive behaviors early within female adolescents admitted to the inpatient psychiatric unit.

Because of this implementation, the caregivers had sufficient time to implement verbal de-escalation to manage this aggressive behavior without causing harm or affecting the rapport between the providers and the patient. A decrease in the use of physical restraints suggests improved healthcare in the psychiatric unit where the project took place. The verbal de-escalation training content is adapted from the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup when caring for the agitated patient (Richmond et al., 2012). Additionally, the AAEP Project BETA (Best practices in Evaluation and Treatment of Agitation) De-escalation Workgroup Consensus Statement, which outlines ten domains of verbal de-escalation, has been used extensively in other research (Misitano, 2017).

Limitations

Initially, providers and staff expressed enthusiasm for the intervention and they were eager to use the MOAS tool and verbal de-escalation. Some of the limitations of this project include the fact that the project was effective in one of the adolescent female adolescents units in the project setting, but this might not be the case in other settings.

Additionally, some providers and staff were unwilling to admit that they use physical restraints or admit they were unfamiliar with the MOAS scale and verbal de-escalation techniques spelled out by the AAEP Project BETA. This insufficient information limited the DNP student from offering detailed training due to the assumption that the providers and staff in the project site were somewhat familiar with the intended intervention.

When the intervention period began, providers and staff were not willing to attend training sessions, as scheduled, on how to use MOAS tool and verbal de-escalation.

Most of the providers and staff claimed that the training sessions collided with their working shift, and therefore, adjustment to accommodate all of them was challenging. Majority of the providers and staff in the project site preferred using physical restraints before trying other alternatives, and therefore, it was challenging to convince them to embrace the MOAS tool and verbal de-escalation during the intervention.

Recommendations

Teaching the participants the importance of this intervention project would be necessary to ensure maximum cooperation and obtaining adequate information needed to achieve project objectives. Recommendations to ensure the continuation of the intervention would include allocation of more time and extensive training regarding the importance of reducing physical restraints while embracing verbal de-escalation techniques. Advocating for teamwork approach would help the providers and staff in the psychiatric unit to identify the presence of aggression early enough with the MOAS tool and apply the suitable approach to calm antagonistic patients using verbal de-escalation. Mental health providers should read and understand the ten domains of verbal de-escalation as detailed in the AAEP Project BETA providers and staff regularly to ensure they refrain from using physical restraints. Providers and staff should undergo training on the importance of embracing MOAS tool and verbal de-escalation after every four months to reduce physical restraints to the minimum as possible.

Implications for Practice

The psychiatric community needs to come up with new policies that address de-escalation techniques as well as restraint usage. These policies should entail practice guidelines

that include introducing a MOAS tool that help to detect aggression early enough. Moreover, practice guidelines should offer verbal de-escalation training every three months to motivate and encourage providers and staffs as well as newly employed caregivers to use verbal de-escalate to manage aggression in their respective units.

Additionally, the guidelines should ensure monitoring of time spent to restrain, when physical restraint is inevitable, to avoid exceeding the recommended time, which is 27 minutes of restraints per 1,000 hours of inpatient psychiatric hospitalization. By implementing these changes, restraint usage should occur, if and only if is necessary, leading to better patient outcomes with a decrease in injuries and an increase in mental health treatment goals.

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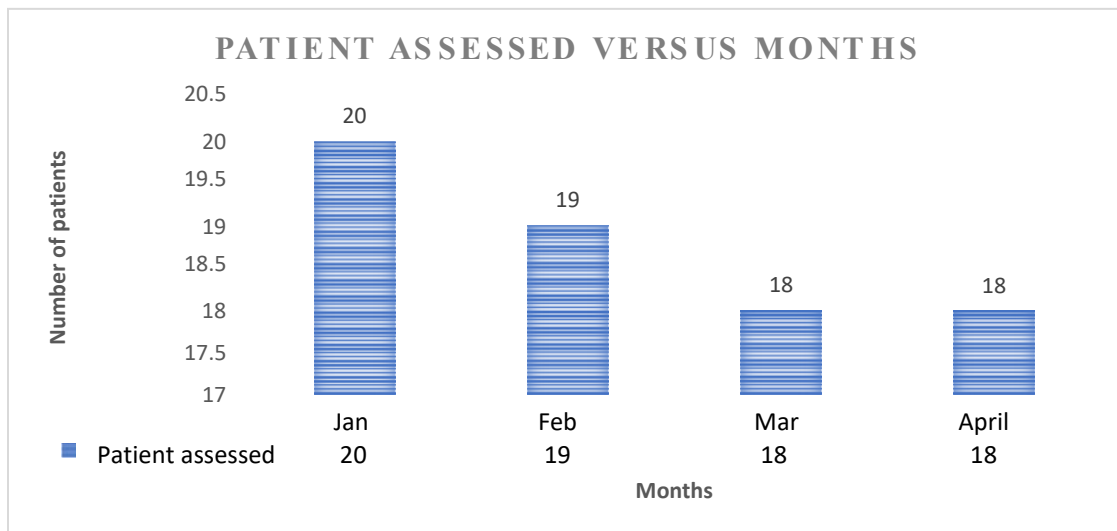
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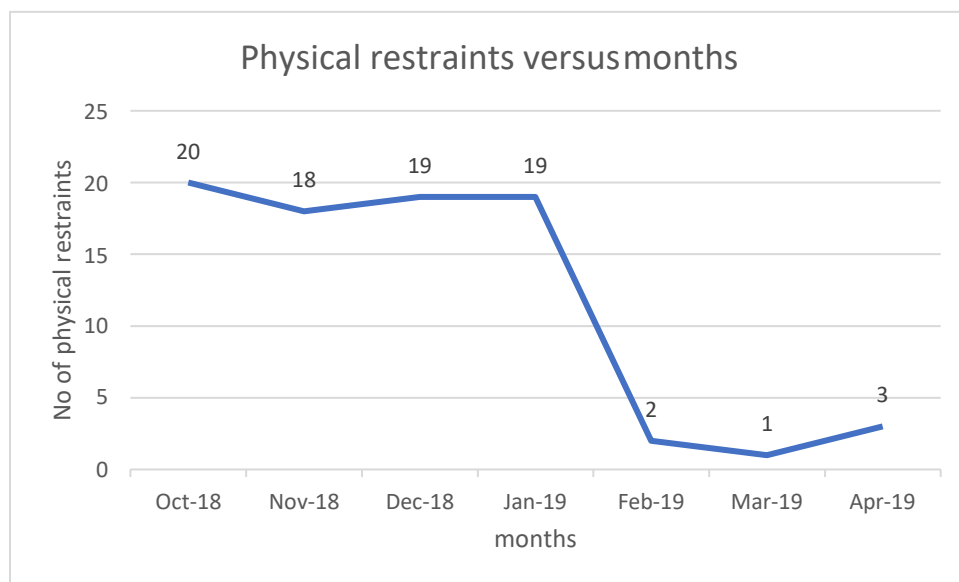
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Appendix A: Figure 1. Patients Assessed Versus Months

*Figure 1. Patients assessed versus months.*

Appendix B: Figure 2. Number of physical restraints per month

*Figure 2.* Number of physical restraints per month.

Appendix C: The Modified Overt Aggression Scale (MOAS) Handout

Patient _____

Rater _____ Date _____

INSTRUCTIONS

Rate the patient's aggressive behavior over the past week. Select as many items as are appropriate.

SCORING

1. Add items within each category.
2. In the scoring summary, multiply sum by weight and add all the weighted sums for total weighted score. Use this score to track changes in level of aggression over time.

Verbal Aggression:

Verbal hostility, statements, or invectives that seek to inflict psychological harm on another through devaluation/degradation, and threats of physical attack.

___ **0** No verbal aggression

___ **1** Shouts angrily, curses mildly, or makes personal insults

___ **2** Curses viciously, is severely insulting, has temper outbursts

___ **3** Impulsively threatens violence toward others or self

___ **4** Threatens violence toward others or self repeatedly or deliberately (e.g., to gain money or sex)

___ **SUM VERBAL AGGRESSION SCORE**

Aggression against Property:

Wanton and reckless destruction of ward paraphernalia or other's possessions.

___ **0** No aggression against property

- ___ 1 Slams door angrily, rips clothing, urinates on floor
- ___ 2 Throws objects down, kicks furniture, defaces walls
- ___ 3 Breaks objects, smashes windows
- ___ 4 Sets fires, throws objects dangerously

___ **SUM PROPERTY AGGRESSION SCORE**

Autoaggression:

- ___ 0 No Autoaggression
- ___ 1 Picks or scratches skin, pulls hair out, hits self (without injury)
- ___ 2 Bangs head, hits fists into walls, throws self on floor
- ___ 3 Inflicts minor cuts, bruises, burns or welts on self
- ___ 4 Inflicts major injury on self or makes a suicide attempt

___ **SUM AUTOAGGRESSION SCORE**

Physical Aggression:

Violent action intended to inflict pain, bodily harm, or death upon another.

- ___ 0 No physical aggression
- ___ 1 Makes menacing gestures, swings at people, grabs at clothing
- ___ 2 Strikes, pushes, scratches, pulls hair of others (without injury)
- ___ 3 Attacks others, causing mild injury (bruises, sprains, welts, etc.)
- ___ 4 Attacks others, causing serious injury (fracture, loss of teeth, deep cuts, loss of consciousness, etc.)

___ **SUM PHYSICAL AGGRESSION SCORE SCORING**

SUMMARY

Category	Sum Score	Weights	Weighted Sums
Verbal Aggression		X1	
		X2	
Aggression Against Property			
Auto Aggression		X3	

Physical Aggression		X4	
Total Weighted Score			

The MOAS tool will be used as an assessment tool to determine severity and forms of aggression engaged in by females in the psychiatric unit. A Likert scale is used to measure the MOAS scale, which focuses on different types of aggression and the levels of associated severity. It measures four types of aggression, and is valid (Margari et al., 2005).

Appendix D: Debrief Handout

Debriefing is critical to restoring a therapeutic relationship between the patient and the provider.

The Debriefing Process

1. Explain why the intervention was necessary
2. Let the patient explain events from their perspective
3. Teach the patient how to request a “time out” and how to appropriately express their anger
4. Ask for feedback on whether the patient’s concerns were addressed. Questions that you can ask the patient:
  - What works when you are very upset, like you were today?
  - What can we do in the future to help you stay in control?
5. Help put the patient’s concerns into perspective
6. Recognize your part in the situation - how are you portraying yourself
7. When someone is escalated, they are not in learning mode - do not try to teach them anything! - wait until they are de-escalated
8. Do not make assumptions
9. Remember the 10 domains of de-escalation
  - o Respect personal space

- o Do not be provocative
- o Establish verbal contact
- o Be concise
- o Identify wants and feelings
- o Listen closely to what the patient is saying
- o Agree or agree to disagree
- o Lay down the law and set clear limits
- o Offer choices and optimism
- o Debrief the patient and staff

10. Debrief with all staff Members. Find out information such as:

- What do you do when you encounter an agitated patient? Who do you call?
- Address their concerns and recommend improvements for future episodes.

Remember: Prevention is the best way to prevent agitation!

Appendix E: Verbal De-Escalation Training Session Attendance Register

[illegible]

Appendix F: Pre/Post-Test Survey for Verbal De-escalation Training Pre-Test Survey
for Verbal De-escalation Training

Select the number point that establishes your status to each statement. Do **NOT** select more than one answer per row.

Please utilize the comments box to note comments relevant to the statements.

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Comment
1.	I interact with aggressive patients frequently	1	2	3	4	5	
2.	I am satisfied with how I use the tools of verbal de-escalation when dealing with an aggressive patient	1	2	3	4	5	

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Comment
3.	I am satisfied with my capability to manage my personal safety while dealing with an aggressive patient	1	2	3	4	5	
4.	I have sufficient knowledge on how to effectively use verbal de-escalation techniques on an aggressive patient	1	2	3	4	5	

		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Comment
5.	I am satisfied with my capacity to implement verbal de-escalation tools when dealing with an aggressive patient	1	2	3	4	5	

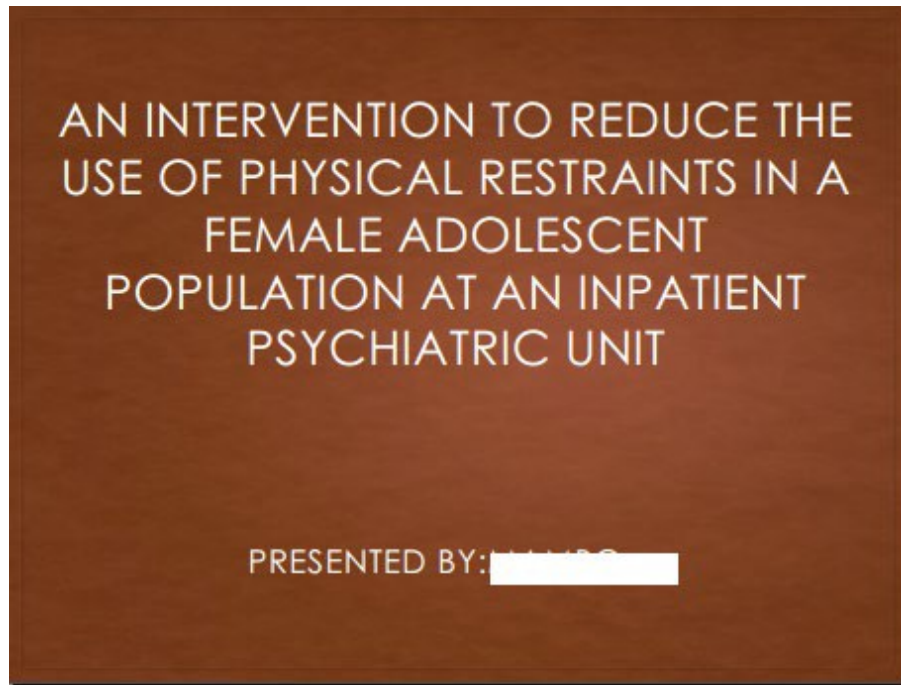
Post-Test Survey for Verbal De-escalation Training

INSTRUCTIONS

Select the number point that establishes your status to each statement. Do **NOT** select more than one answer per row.

Please utilize the comments box to note comments relevant to the statements.

Appendix G: PowerPoint Presentation



PROJECT BETA 10 DOMAINS OF VERBAL DE- ESCALATION

Adapted from: Richmond et al. 2012

PROJECT BETA

- Encompasses 10 domains of de-escalation designed to advocate for a more contemporary and non-coercive approach for providers to engage the patient, establish a collaborative relationship, and continue to verbally de-escalate the patient out of their agitated state.
- Aim to achieve 4 main objectives:
  - Ensure the safety of the patient, staff, and visitors
  - Help the patient manage their emotions and distress in order to better maintain control of their behavior
  - Avoid the use of restraints when at all possible
  - Avoid coercive interventions that escalate agitation

10 DOMAINS OF DE-ESCALATION

(RICHMOND, ET AL, 2012)

1. Respect personal space while maintaining a safe position.
2. Do not be provocative.
3. Establish verbal contact.
4. Be concise; keep the message clear and simple.
5. Identify wants and feelings.
6. Listen closely to what the person is saying.
7. Agree or agree to disagree.
8. Lay down the law and set clear limits.
9. Offer choices and optimism.
10. Debrief the patient and staff

1. RESPECT PERSONAL SPACE

- Normal eye contact
- Maintain at least 2X arm's length distance. Expand that space if patient is severely agitated or paranoid
- Maintain an open path of exit

2. DO NOT BE PROVOCATIVE

- Maintain a calm demeanor with relaxed facial expressions
- Be empathetic
- Convey genuine concern for the patient's situation
- Be aware of your Body Language. It should be congruent with what you are saying
- Speak softly. Avoid an angry or frustrated tone
- Maintain a relaxed stance (Arms uncrossed, Hands open, Knees bent, Hands visible and unclenched)
- Avoid directly facing the patient. Stand at an angle so as not to appear confrontational

3. ESTABLISH VERBAL CONTACT

- Introduce yourself. Who you are and What you are
- Verbalize that your goal is to keep them safe
- You will not allow harm
- You are there to help them regain control
- Last name vs. First names
- One Communicator. Avoid multiple communicators which can lead to confusion and further escalation.

4. BE CONCISE

- Use short sentences or phrases.
- Use language that the patient will understand; simple vocabulary. Complex language can increase confusion and lead to escalation
- Repeat yourself often. This is essential when making requests of the patient, setting limits, and offering choices/alternatives

5. IDENTIFY WANTS AND FEELINGS.

- Some patients only want to vent to an empathetic listener
- Ask the patient to specifically state what their request is regardless of your ability to fulfill it
- Simple statements such as:
  - "I really need to know what you expected when you came here"
  - "Even if i can't provide it, i would like to know so we can work on it"
- Utilize "Free Information" to better identify wants and feelings
  - trivial things the patient says
  - body language
  - past encounters with patient
- Recognizing free information allows the provider to respond empathetically and express a desire to help the patient get what he wants

6. LISTEN CLOSELY TO WHAT THE PERSON IS SAYING.

- Be an active listener
- Pay attention to what is being said
- Use clarifying statements if needed
  - "Tell me if I have this right....."
- Be engaged in the conversation
  - Patient will recognize that you are there for them which will aid in fostering de-escalation
- Miller's Law
  - "To understand what another person is saying, you must assume that it is true and try to imagine what it be could be true of"

7. AGREE OR AGREE TO DISAGREE

- Agree with the patient as much as possible
- Fogging
  - Finding something about the patient's position with which you can agree with
- 3 ways of agreeing with a patient
  - Agree with the truth
  - Agree in principle
  - Agree with the odds
- Delusions
  - Acknowledge that you have never experienced what the patient is experiencing but that you believe he is having that experience
- Agree to Disagree

8. LAY DOWN THE LAW AND SET CLEAR LIMITS

- Set limits
  - Demonstrate your intent to help, but to be abused
- Offer choices
- Propose alternatives
- Establish consequences
- Use positive reinforcement
- Communicate limits in a matter-of-fact way and not in a threatening manner
- Coach the patient in how to stay in control
  - "I really want you to sit down. When you pace, I feel frightened and I can't pay full attention to what you are saying. You can help me understand if you calmly tell me your concerns"
- Maintain "working conditions"
  - Mutual respect for each other

9. OFFER CHOICES

- When a patient has nothing left but to fight or flight, offering a choice can be a powerful tool
- Choice is often the only source of empowerment for the patient who believes physical violence is a necessary response
- Be assertive and quickly propose alternatives to violence
- Offer things that will be perceived as acts of kindness (blankets, magazines, access to a phone, food, drink)
- Choice must be realistic
- Never promise something that you cannot provide
  - Don't promise a chance to smoke when the hospital has a no smoking policy

BROACHING THE SUBJECT OF MEDICATIONS

- When all attempts to verbally de-escalate fail, more coercive measures may need to be taken as a last resort
  - restraints
  - injectable medications
- The goal of medicating an agitated patient is to calm. NOT sedate
- When medications are indicated, offer choices to the patient
- Do not rush to give the medication, but be careful not to delay

OPTIMISM

- Be optimistic and provide hope
- Let the patient know that they are safe and that you are there to help them regain control
- Give realistic time frames and agree to help the patient work on the problem
- For example, when a patient states: "I want to get out of here". The provider can respond "I want that for you as well, I don't want you to have to stay any longer than is necessary. How can we work together to help you get out of here?"

10. DEBRIEF THE PATIENT AND STAFF

- Debriefing is critical to restoring a therapeutic relationship between the patient and the provider
- The debriefing process
  - Explain why the intervention was necessary
  - let the patient explain event from their perspective
  - teach the patient how to request a "time out" and how to appropriately express their anger
  - Ask for feedback on whether the patient's concerns were addressed
  - help put the patient's concerns into perspective
- Prevention is the best way to prevent agitation
  - "what works when you are very upset, like you were today? What can we do in the future to help you stay in control?"
- Don't forget to debrief with all involved staff members
  - Address their concerns and recommend improvements for future episodes

RECAP: GOALS OF TREATING AGITATION

- Reduce distress, anger, and anguish
- Reduce and prevent dangerous behaviors
- Calm to tranquility without the intent to medicate or sedate
- Minimize the need for physical restraints
- Create a therapeutic alliance
- Collaborate to decrease future episodes of acute agitation

DON'T FORGET TO CHART!

- Be as detailed as you can
- If you utilized any of the 10 domains, discuss what worked and what didn't
- An easy way to reinforce and teach de-escalation techniques to colleagues who may also see the patient

Appendix H: Letter of Support

Christina Chen, MD

Waco Center for Youth

3501 N. 19th St

Waco, Texas 76708

Mambo Ndingwan

Ila Faye Miler School of Nursing & Health Professions

University of the Incarnate Word

4301 Broadway

San Antonio, TX 78201

Dear Mambo Ndingwan:

I have reviewed your project proposal regarding the implementation of a strategy to reduce the selection of physical restraint as a way to manage adolescent inpatients in a psychiatric unit as well as increasing verbal de-escalation as an intervention strategy. The use of physical restraint has been a problem in this facility, and therefore, I grant you an opportunity to carry out your DNP project at Waco Center for Youth, a residential psychiatric treatment center located in central Texas in the 76708 zip code, as the site for your DNP project.

Aggression is the main cause of using physical restraint in this facility. Physical restraint can lead to adverse effects for patients and staff. Disadvantages of using this strategy include the increased risk of experiencing psychological distress, negative emotions for patients, family members, and staff. Physical restraints can also trigger further stimulation of aggression while damaging therapeutic alliances between staff and patient. There is also the concern of physical

injury and death.

I, therefore, support your efforts to introduce the use of MOAS scale to detect aggressive psychiatric inpatients as well as educating all mental health providers/staff to implement verbal de-escalation rather than physical restraints. I pledge my full support on this project, and I look forward to seeing the results.

Sincerely-