Strategies to Lower Risk in the Management of Acute Aggression

Background

Acute aggression poses a serious risk of harm to patients, visitors, and staff in the acute care setting.

- Agitation is the **leading cause** of staff injuries in the acute care setting
- 67% of staff injuries occur **during** the restraint process

Disparities in the use of physical restraints are well documented.

- Factors contributed to the practice disparity: race/ethnicity, time of day, & staff shortages

Importance of Issue

Patient	Physical restraints carry a risk of physical and psychological complications
Community	Socioeconomically distressed populations are at higher risk of physical restraint, further exacerbating health inequities
Nursing Profession	Workplace violence negatively impacts the ability to provide safe and equitable care

Framework

The Model for Evidence-Based Practice Change

Assess need for change → Locate evidence → Synthesize *best* evidence → Design **pilot* → Implement & Evaluate → Integrate & Maintain

- Designed for interprofessional teams
- Guides multiple practice change projects
- Incorporates opportunities for feedback and modification

Key Concepts & Outcomes

Patient-centered care should be provided through safe and least restrictive means

By May 2024, duration of physical restraint application will decrease by 50%

By May 2024, incidence of staff injury related to WPV will decrease by 50%

Interventions & Solutions

Individual Level	• BARS screening at triage • Involvement in WPV team • Change champions
Unit Level	• Inservice sessions & educational materials • Increase availability of MAB training sessions
Policy Level	• Development & implementation of a standardized aggression order set modeled after Project BETA guidelines • More security officers

Project BETA Components

- De-escalation
- Triage Screening (BARS)
- Medical Evaluation
- Pharmacotherapy
- Psychiatric Evaluation
- Restraint

Behavioral Activity Rating Scale (BARS)

1. Difficult or unable to arouse
2. Asleep but responds normally to verbal or physical contact
3. Drowsy, appears sedated
4. Quiet & awake (normal activity)
5. Signs of overt (physical or verbal) activity, calms down with instructions
6. Extremely or continuously active, not requiring restraint
7. Violent —> **REQUIRES RESTRAINT**

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Key Players

- Medical Director
- Nurse Manager
- Adult Patients & Families
- Staff Nurses
- Security Officers

Evaluation

Process	Impact

• Quarterly EMR audits
  • BARS screening
  • Physical restraint use
• Staff attendance to MAB training
• Staff attendance to WPV team meetings
	• Quarterly audits
	  • Order set compliance
	  • Code Gray log
	• Pre & post surveys for pilot interventions
	• Compare post-pilot data to baseline

Abbreviations
BARS - Behavioral Activity Rating Scale; BETA - Best Practices in the Evaluation and Treatment of Agitation; EMR - Electronic Medical Record; MAB - Management of Assaultive Behavior; WPV - Workplace Violence

References

Campbell, E., Jessee, D., Whitney, J., Vupputuri, S., & Carpenter, J. (2021). Development and implementation of an emergent documentation aggression rating tool: Quality improvement. *Journal of Emergency Nursing, 47*(5), 696–706. https://doi.org/10.1016/j.jen.2021.04.011

Carreras Tartak, J. A., Brisbon, N., Wilkie, S., Sequist, T. D., Aisiku, I. P., Raja, A., & Macias-Konstantopoulos, W. L. (2021). Racial and ethnic disparities in emergency department restraint use: A multicenter retrospective analysis. *Academic Emergency Medicine, 28*(9), 957–965. https://doi.org/10.1111/acem.14327

Conteh, E., Alorda, A., Lebowitz, D., & MacIntosh, T. (2023). Disparities in the use of chemical and physical restraints in the emergency department by race/ethnicity. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-022-01504-2

Coralic, Z., Rader, E. S., Vinson, D. R., & Wilson, M. P. (2022). Haloperidol versus ziprasidone with concomitant medications and other predictors of physical restraint duration in the emergency department. *The Journal of Emergency Medicine, 62*(5), 636–647. https://doi.org/10.1016/j.jemermed.2021.12.018

Gottlieb, M., Long, B., & Koyfman, A. (2018). Approach to the agitated emergency department patient. *The Journal of Emergency Medicine, 54*(4), 447–457. https://doi.org/10.1016/j.jemermed.2017.12.049

Jin, R.O., Anaebere, T.C. & Haar, R.J. (2021), Exploring bias in restraint use: Four strategies to mitigate bias in care of the agitated patient in the emergency department. *Academic Emergency Medicine, 28*(9), 1061-1066. https://doi.org/10.1111/acem.14277

Melnyk, B.M. & Fineout-Overholt, E. (2019). *Evidence-based practice in nursing & healthcare: a guide to best practice.* (4th ed.) Wolters Kluwer.

Roppolo, L. P., Morris, D. W., Khan, F., Downs, R., Metzger, J., Carder, T., Wong, A. H., & Wilson, M. P. (2020). Improving the management of acutely agitated patients in the emergency department through implementation of Project BETA (Best Practices in the Evaluation and Treatment of Agitation). *Journal of the American College of Emergency Physicians Open, 1*(5), 898–907. https://doi.org/10.1002/emp2.12138

Schnitzer, K., Merideth, F., Macias-Konstantopoulos, W., Hayden, D., Shtasel, D., & Bird, S. (2020). Disparities in care: The role of race on the utilization of physical restraints in the emergency setting. *Academic Emergency Medicine, 27*(10), 943–950. https://doi.org/10.1111/acem.14092