Prevention and Management of Agitation in Emergency Departments

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Introduction

Agitation in patients in emergency departments (EDs) is becoming more prevalent with 1.7 million episodes annually in the United States *(Holloman, 2012)*. While the extent of aggression associated with agitation has not been clearly established, some patients who are agitated are at risk of becoming aggressive and violent, and can cause physical and psychological harm to themselves, other patients and staff *(Richmond, 2012)*.

It's important to note that **agitation is a symptom**, whether of mental illness, substance misuse, past trauma, or something else. Properly assessing agitation and providing supports to people who are experiencing agitation does prevent some aggressive incidents. Evidence shows that among risk factors for incidents of violence in emergency department is inadequate or nonexistent training on the management of assaultive behaviors, understaffing, and working alone *(Solorzano Martinez, 2016)*.

Additionally, the ED environment itself can increase agitation: A 2020 narrative literature review found that between 46% and 89% of people who use mental health services have been exposed to past traumatic events and the ED environment can trigger fears or traumatic memories *(Molloy, 2020)*.

> *"Minnesota health systems have found that collaborating to improve safety makes infinitely more sense than competing on patient or employee safety metrics. In that spirit, ICSI fostered the collaborative effort that resulted in this ED agitation management package, which can promote safety for all in one of the highest risk hospital departments."*
>
> — JESSICA MALONE MN, RN, PHN
> *Clinical Care Improvement Manager Psychiatry Service Line, Hennepin Healthcare*

Setting up processes to support people experiencing agitation not only is better patient care, it is critical in caring for staff. Being able to assess and intervene for people experiencing agitation also aids staff in identifying when people are at risk of aggression. A systematic review on workplace violence in the emergency department found that emergency department workers are exposed to significant rates of physical and verbal abuse. It also found that under-reporting of workplace violence in the emergency department to be common which contributes to the difficulty in accurately tracking violence *(Taylor, 2011)*. Emergency departments and inpatient psychiatric units have the highest rate of violent incidents compared to other health care settings *(Joint Commission, 2018)*.

Increased incidents of violence lead to staff burnout and low morale and subsequently higher turnover rate *(Joint Commission, 2018)*. In addition to staff, other patients are also at risk for being victimized if agitation and aggressive behaviors are not properly assessed and managed.

Objective

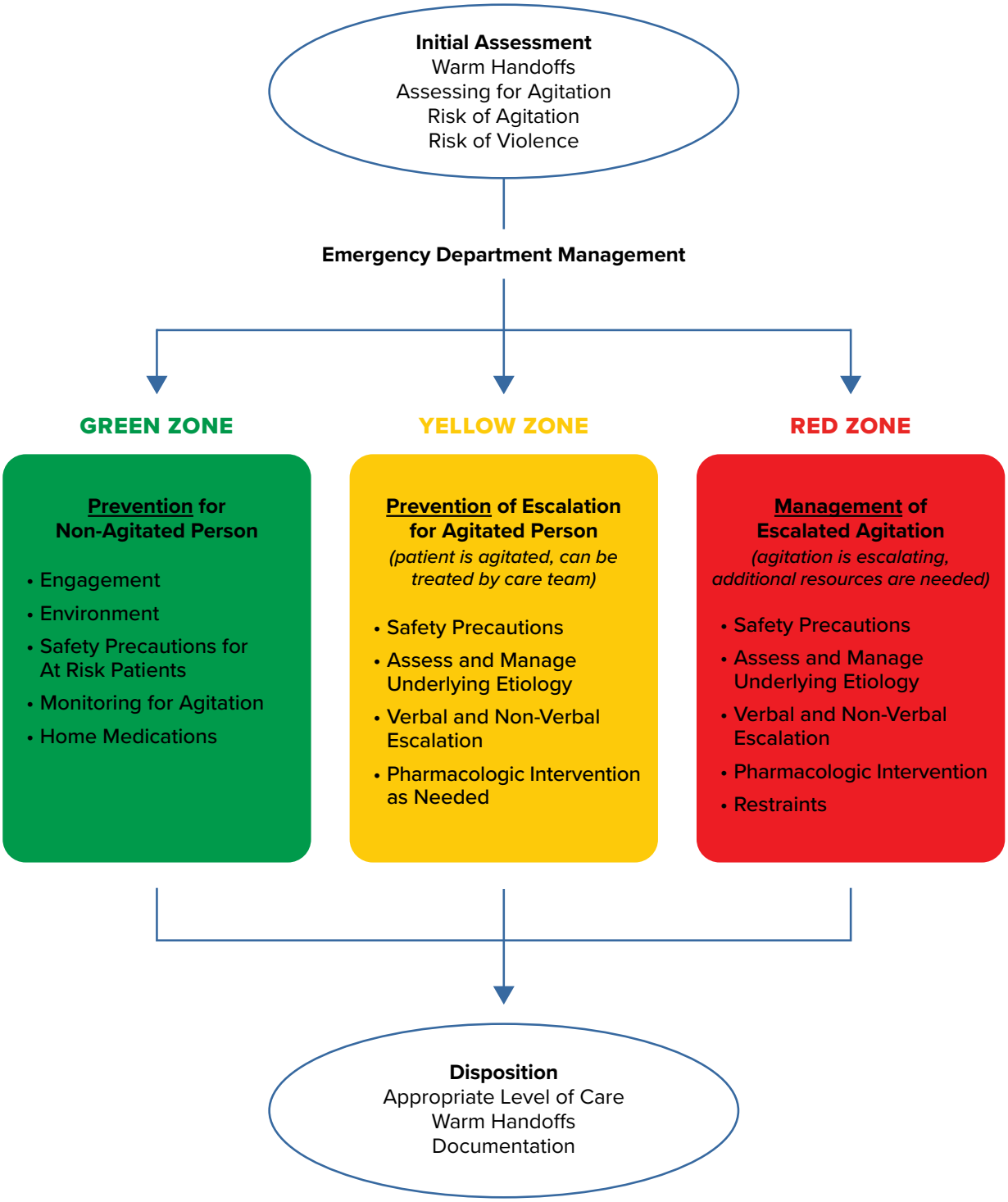
Our goal for these recommendations is to shift the current thinking and practices around addressing agitation from a reactive to a proactive response: preventing agitation or escalating agitation from occurring and providing a safe and therapeutic environment for all patients. This guide is intended to help organizations develop policy and procedures around agitation and violence prevention.

In the absence of high-quality evidence, this group seeks to provide practical guidance to ED providers. Implementation of these practices may vary, depending on patient populations and ED resources. We have provided questions throughout to help leaders discover possible areas for systems improvement.

Scope:
This document focuses on the adult population (18 years of age and older) who present in the Emergency Department. For populations younger than 18 years of age, refer to Project BETA which has published recommendations for Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department (Gerson, 2019).

Literature:
It is important to note that literature on agitation in the ED, particularly regarding interventions, is limited. The following document is based on expert work group consensus as well as that of Project BETA, a work group convened by the American Association of Emergency Psychiatrists. Several organizations in the working group have applied BETA work in their EDs with success. We have referenced the Project BETA papers throughout this paper (papers are available for free download at the link provided). See references sections for full citations.

Reactive to Proactive Response Framework



Recommendations

Note: Literature on agitation in the ED, particularly regarding interventions, is limited. The following document is based on expert work group consensus as well as that of Project BETA, a work group convened by the American Association of Emergency Psychiatrists.

Initial Assessment

1. **Warm Handoffs from Law Enforcement/First Responders**
   Note: There was no literature found to support guidance on this topic. The expert work group consensus is based on the existing practices and expert opinion and includes the following:
   - A "heads up" from law enforcement/ambulance prior to arrival to ED. This will give time for the ED staff to prepare for an arrival of a patient and provide an understanding on the level of care and resources needed upon arrival. This could potentially help reduce delays in rooming and getting patients to appropriate level of care.
   - This "heads up" should include thorough collateral information and documentation of events leading to presentation including understanding/knowledge of persons close to the patient which may be helpful during the assessment to disposition process.
   - Suggested key questions to include in the "heads up" for patients in psychiatric or substance abuse distress arriving to the ED:
     - What was the reason for the call and who made it?
     - Any suicidal concerns or threats to others?
     - Risk for overdose?
     - Other intoxicants/substance abuse?
     - Was patient cooperative and any medication needed for sedation/anxiolysis?
     - Had to utilize restraints?
     - Has patient been placed on hold?
     - Any other medical complaints, reported trauma or concerns thereof?
     - Known psychiatric history?
     - Where was patient picked up and what is home living situation?
     - Any witnesses for potential collateral contact information?

QI: How do our staff and law enforcement/first responders work together to support patients' care transitions?

2. Assessing for Agitation/Risk of Agitation on Arrival

On arrival to the ED, it is useful to evaluate the patient to determine if they are: 1) currently agitated, 2) at risk for agitation and/or 3) at risk for violent behavior. There are tools that may be used to assess current state of agitation or risk of violence in the ED. It is important to note that assessment tools can help, but should not be used in place of clinical judgement.

Project BETA and Assessment

The Project BETA consensus statement does not endorse a specific tool; however, it finds the Behavioral Activity Rating Scale (BARS) easy to use reliably by both medically trained providers and those who are not medically trained *(Nordstrom, 2012)*.

Summary of Agitation Assessment Tools

- **Behavioral Activity Rating Scale (BARS)** is a scale for measuring behavioral activity in acutely agitated patients. It is validated for measurement of behavioral activity in acutely agitated patients with psychosis *(Swift, 2002)*. The initial BARS score is based not only on the patient's presentation, but also on his behavior before arrival to the ED, hence a reliable report from transport, where applicable, is beneficial. Any score other than a 4 should trigger an evaluation by a clinician and establish the urgency of that evaluation *(Nordstrom, 2012; Richmond, 2012)*. The following link from Project BETA paper *(Nordstrom, 2012)* provides BARS scoring table and algorithm for management: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298208/

- **OASS (Overt Agitation Severity Scale)** is validated in young adult psychiatric inpatient patients *(Kopecky, 1998)*.

- **OASS (Overt Aggression Severity Scale)** measures aggressive behaviors in adults and children. On the Overt Aggression Scale (OAS), aggression is divided into four categories: verbal aggression, physical aggression against objects, physical aggression against self, and physical aggression against others. In addition, specific interventions related to each aggressive event can be recorded on the OAS *(Silver, 1991; Yudofsky, 1986)*. The full scale is available in Silver & Yudofsky, 1991.

Assessing for Risk of Violence in ED

Evidence shows association of the following patient-related risk factors with incidents of violence in emergency department: 1) male patient, 2) younger age, 3) mental health patients who are not taking their medications, 4) patients brought in by police, or brought in by ambulance, 5) patients who presented to the ED involuntarily and had a criminal history *(Cabilan, 2019)*.

Additional factors for risk of violence toward staff include: environmental factors such as poor security, delays in service, and working closely with potentially dangerous individuals; and staff factors such as inadequate or nonexistent training on the management of assaultive behaviors, understaffing, and working alone *(Solorzano Martinez, 2016)*.

Summary of Risk of Violence Assessment Tools

- **Brøset Violence Checklist (BVC)** uses six common behaviors (confusion, irritability, boisterousness, verbal and physical threats, and attacking objects) to predict an acute episode of violence in hospitalized psychiatric patients. The scoring levels are: Zero suggests that risk of violence in the next 24 h is low; 1–2 corresponds to moderate risk; and a score of ≥3 is high risk

of violence. A study of 109 patients in inpatient psychiatric units found BVC to predict violence within the next 24-hour period with moderate sensitivity and good specificity *(Almvik, 2000)*. A recent systematic review further confirmed this finding *(Cabilan, 2019)*. This tool is copyrighted and can be requested at: https://www.frenzs.org/bvc-broset-violence-checklist/

- **Violence/Aggression Assessment Checklist (VACC)** – is an adaptation of BVC specifically for ED. It assists in predicting imminent violent behavior within the next 24 hours by assessing for six behaviors: confused, irritable, boisterous, physically threatening, verbally threatening, attacking objects. This tool is available at: https://www.theroyal.ca/sites/default/files/2019-08/Violence_Aggression_Assessment_Checklist.pdf

- **MIAHTAPS** is a violence risk assessment tool developed by HealthPartners Regions Hospital. It assesses for seven indicators of behaviors and past history: **M**-altered mental status, **I**-irritable, **A**-agitated, **H**-history of violence, **T**hreatening verbally, **A**ttacking, throwing objects, **PS**-pacing and/or staring. It combines information from Broset, BARS and STAMP. The tool is available upon request from HealthPartners – Regions Hospital in St. Paul, MN.

- **Violence Risk Screen Decision Support in Triage (VRSDSiT)** – developed in Australia. An ED tool for nursing staff to use at triage. It starts with a question "At risk of violence/or aggression?" which prompts nurse to determine presence of risk factors such as involvement in assault, intoxication, acute mental health symptoms, brought in by police, history of violence and behavioral cues (i.e., uncooperative, hostile, intrusive or making verbal or physical threats). If the answer is yes, the patient is flagged as at risk for violence. This tool has moderate sensitivity and good specificity *(Cabilan, 2019)*. In the tool dissertation report, the triage nurse used clinical judgement to determine if there was risk for violence. This process was found to be feasible, acceptable to clinical staff, integrated into current triage processes, and reflected the public's expectations of care. Communication of risk was facilitated using the existing clinical information system and normal work flow within the ED. Overall, there was a reduction in time staff engaged in responding to aggression; access to care was unchanged. However, there was an increase in the use of coercive practices following implementation of this risk screening process *(Daniel, 2015)*.

  Reference: Daniel C. An evaluation of violence risk screening at triage in one Australian emergency department (Dissertation). Melbourne: The University of Melbourne, 2015.

- **STAMP** assessment tool provides indicators for violent behavior using five observable behaviors that indicate danger to others. STAMP mnemonic (**S**taring and eye contact, **T**one and volume of voice, **A**nxiety, **M**umbling, and **P**acing). While a case study identified these observable behaviors to indicate a potential for violence at presentation at an emergency department *(Luck, 2007)*, a recent scoping review found no specificity, sensitivity or predictive value of this tool *(Cabilan, 2019)*. A variation of this tool STAMP – EDAR (Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling, and Pacing - Emotions, Disease Process, Assertive/non-Assertive, Resources) had the same finding in the review *(Cabilan, 2019)*.

  The tool is available in Luck 2007 article.

QI: What is our process for assessing agitation, risk of agitation, and risk of violence in the ED?

ED Management

Green Zone (Prevention for Non-Agitated Patient)

1. Engagement

A 2020 narrative literature review found that between 46% and 89% of people who use mental health services have been exposed to past traumatic events and the ED environment can trigger fears or traumatic memories *(Molloy, 2020)*. Applying the principles of trauma-informed care can potentially minimize this experience in these patients while in ED *(Molloy, 2020)*.

Trauma-informed care and cultural considerations are important parts of patient care. It is important that staff have training in non-violent crisis intervention and early recognition/de-escalation of agitation that consider patient cultural preferences and historical and present traumas that may guide approach to care decision-making. There are no specific tools related to trauma-informed care and agitation in the ED. The following resource may be helpful: Trauma Informed Care – Implementation Resource at https://www.traumainformedcare.chcs.org/

QI: **How might we better engage and support patients in the ED?**
Do we effectively use the trauma-informed care frameworks?
Are there common trauma that our patients may have experienced that we should better understand? (Migrants from war zones, racism...).

2. Environment

When possible, the least restrictive environment is preferable. Consider having food and beverage available, particularly for patients with extended stays.

An alternative to the stressful ED environment is EmPATH and other types of observational units, designed for patients with behavioral health needs. It is an area separate but adjoined to the regular ED where patients can be assessed and treated by behavioral health professionals in an environment that is more calming.

There are conflicting thoughts about posting signs about agitation/violence. While outlining unacceptable behaviors may help, there are also concerns that it could encourage that behavior in patients who are seeking interaction with law enforcement.

In the UK, signage about the process and time expectations within EDs have been helpful in decreasing agitation and violence *(Griffiths, 2013)*.

QI: **What can we do differently to make our environment both safe and therapeutic?**

3. Safety Precautions for At Risk Patients

Although non-agitated patients do not pose an immediate threat, it may be prudent to consider safety precautions for patients with a history of agitation or other symptoms/behaviors that concern staff. Such precautions may include separate rooming, scrubs, and/or a sitter. Systems differ in the use of these precautions routinely or a case-by-case basis. Both the safety of the patient, the safety of other patients, and the safety of staff all need to be considered when deciding what precautions are warranted.

It is important to consider any negative impact these precautions may have on the patient and whether they may provoke agitation.

QI: What routine safety precautions have been taken for non-agitated patients who may be at higher risk of agitation?

4. Monitoring for Agitation

Patients should be monitored throughout their ED stay for new or changing agitation. This can be done clinically and/or with the aid of a tool such as BARS.

QI: How do we monitor for agitation during the ED stay?

5. Home Medications

Delay or omittance of a patient's regular medications may lead to agitation. It is the consensus of this work group that wherever possible, giving home medications (in particular, those related to behavioral health) should be considered by the treatment team while the patient is in the ED.

QI: How often are home medications delayed or omitted, particularly for behavioral health patients? What policies are in place regarding home medications?

Yellow Zone (Prevention of Escalation in Agitated Patient)

1. Safety Precautions

For the agitated patient, safety precautions are especially important. This involves considering the safety of the patient, other patients, and staff.

Patient considerations:
Decide whether the patient should be changed into hospital scrubs/clothes and whether a sitter is needed. Refer to organizational policies and regulatory requirements when deciding on this.

Physical environment considerations: *(Stowell, 2016)*

- Easily accessible alarm systems
- Doors that open outward, cannot be locked from inside, allow easy access from the outside in event of emergency
- Barrier-resistant doors, which contain a small compact door within the door
- Location close to staff areas
- Unobstructed viewing window

QI: What additional safety precautions are taken for agitated patients? Are there changes you need to make in the physical environment that would increase safety while considering trauma informed care principles?

2. Assess and Manage Underlying Etiology

The patient should be assessed for underlying medical and psychiatric conditions that may cause or contribute to the agitation. Labs and imaging should be based on clinical judgment. The following is differential diagnosis:

Differential Diagnosis Underlying Agitation *(Nordstrom, 2012)*

Medical	Psychiatric	Intoxication
• Head trauma • Encephalitis, meningitis, or other infection • Encephalopathy (particularly from liver or renal failure) • Exposure to environmental toxins • Metabolic derangement (e.g., hyponatremia, hypocalcemia, hypoglycemia) • Hypoxia • Thyroid disease • Seizure (postictal) • Toxic levels of medications (e.g., psychiatric or antiseizure)	• Psychotic disorders • Mania • Agitated depression • Anxiety disorders	• Alcohol • Club or recreational drugs (cocaine, ecstasy, ketamine, bath salts, inhalants, methamphetamines)

- **Labs and imaging should be based on individual patient presentation.** See Medical Clearance Evaluation for more information.
- Information from both medical and psychiatric evaluation should be thoroughly documented.
- To ensure legal compliance, EDs should be aware of latest laws in their area around involuntary treatment and commitment, salutatory reporting requirements based on information obtained during assessment, and duty to warn others of the risk.

QI: What routine labs or other evaluation protocols are there for a patient presenting with agitation? Do these need updating? Are they individualized per patient presentation?

3. Verbal and Non-Verbal De-Escalation

Verbal de-escalation is a method to calm the agitated patient and gain patient's cooperation in the evaluation and treatment of the agitation and reduce involuntary medication, seclusion, and physical restraints. Non-verbal de-escalation includes interpersonal non-verbals and the physical environment.

The following are Project BETA guidelines on preparing to conduct verbal de-escalation *(Richmond, 2012)*.

1. *Physical Space Should Be Designed for Safety*

   Main points:
   - Use moveable furniture to help create a safe environment. Emergency departments may also use stationary furniture, so that the patient cannot use the objects as weapons. However, Project BETA also cautions that latter may create a false sense of security.
   - Avoid extremes in sound, wall color, and temperature of the environment as these can exacerbate sensory stimulation.
   - Ensure adequate exits.
   - Remove or secure objects (pens, sharp objects, table lamps, etc.) that may cause injuries to others. Monitor objects that cannot be removed.

2. *Staff Should Be Appropriate for the Job*

   Main points:
   - Clinicians must be good at multitasking and be able to respond quickly to changing patient priorities.
   - Temperament for working with patients who are agitated.
   - Self-awareness such that staff members are able to recognize their own negative reactions or behaviors toward agitated patient's behaviors. Staff should be able to recognize when they are engaging into behaviors (e.g., arguing, tendency to retaliate, or become defensive) that can only worsen their interaction with the patient.
   - Ability to seek additional help when they are no longer able to deal with an agitated patient.
   - Any provider can learn de-escalation skills. The essential skillset includes a helpful attitude, starting with positive regard for the patient and the capacity for empathy. Clinicians need to also be able to differentiate when cognitive issues, intellectual disability, delirium, psychosis, intoxication or personality disorder affect patient's ability to conform to instructions.

3. *Staff Must Be Adequately Trained*

   Main points:

   - Practice by role playing. Also consider practicing skills with non-agitated patients who are unable to follow directions because of cognitive issues or other conditions.
   - Use verbal loop with patients by mirroring/reflecting what they are saying. Persistence is key. It is important to not give up after a few tries of verbal loops. If patient is not responding to de-escalation efforts, the clinicians should persist in repeating it, especially in situations where patient is not showing signs of becoming violent.
   - Successful de-escalation can be successfully done in 5-10 minutes, depending on patient complications.
   - Some patients may not be able to engage in de-escalation efforts due to delirium or other conditions.

4. *An Adequate Number of Trained Staff Must Be Available:*

   Main point:

   - The de-escalation team should consist of 4 to 6 team members made up of nurses, clinicians, technicians, and police and security officers, if available.

5. *Use Objective Scales to Assess Agitation*

   Main points:

   - Use an objective scale such as BARS to assess for level of agitation.
   - Base the initial BARS score not only on the patient's presentation, but also on the behavior before arrival at the emergency facility. Any score other than a 4 should trigger an evaluation by a clinician and the urgency established.

6. *Clinicians Should Self-Monitor and Feel Safe When Approaching the Patient*

   Main point:

   - Much of the clinician/patient communication occurs via body language, especially tone of voice. It is important for clinician to remain calm in their interaction with agitated patient in order to be effective.

7. *10 Domains of De-Escalation Exist that Help Clinicians' Care of Agitated Patients*

   i. *Domain I: Respect Personal Space*
   ii. *Domain II: Do Not Be Provocative*
   iii. *Domain III: Establish Verbal Contact*
   iv. *Domain IV: Be Concise*
   v. *Domain V: Identify Wants and Feelings*
   vi. *Domain VI: Listen Closely to What the Patient Is Saying*
   vii. *Domain VII: Agree or Agree to Disagree*
   viii. *Domain VIII: Lay Down the Law and Set Clear Limits*
   ix. *Domain IX: Offer Choices and Optimism*
   x. *Domain X: Debrief the Patient and Staff*

   Detailed recommendations for each of the domains are explained in Richmond et al (2012).

Additional De-Escalation Tips Found useful and contributed by Members of the ICSI Working Group

- Keep body language alert, but relaxed. Don't fold your arms in front of your chest or hands in your pockets (this makes it unsafe if someone strikes as you would have decreased reaction time). Have hands positioned in front of you, with palms upwards (this shows the other person you are not hiding anything in your hands, as well as keeps your hands and arms ready to deflect any physical blows).
- Avoid movements that could be perceived as threatening (e.g. hands at the hip).
- Angle lower body/feet 45 degrees from the person. This allows you to protect your "sensitive areas" but also sets up your feet to swiftly move sideways if you need to deflect any physical blows. This is also less intimidating than a completely forward stance.
- Stay two arms lengths away; it gives space to the agitated patient and keeps your body safe as well.
- Maintain a neutral face, do your best to appear calm and level headed. Your increased anxiety can increase the anxiety in the patient. Avoid facial expressions and overreacting.
- If safe, maintain eye level positioning. If the patient is sitting, you sit. If the patient is standing, you stand.
- Limit overall touching. Agitated patients can view touching as hostile, even if the touch is meant to calm someone (i.e., limit touching someone's shoulder when agitated even though this is a natural reaction we make to comfort someone)
- Have awareness of positioning in a room to avoid feeling trapped/backed into a corner and providing a sense of safe exit (staff and patient).
- You can acknowledge and emphasize with a patient's feelings but not excuse the behaviors (i.e., I understand why you would be upset, but it is not okay to threaten me).
- Don't argue with an escalated patient. If their tone is heightened, a patient is less likely to respond to logic or argument.

QI: How are staff trained in verbal and non-verbal de-escalation? Do staff feel it is sufficient? Are there cultural or other norms in the population(s) you serve that need to be considered in your de-escalation plans and training?

4. Pharmacologic Interventions

Nonpharmacologic approaches, such as verbal de-escalation and reducing environmental stimulation (quiet room, low lighting), should be attempted, if possible, before medications are administered.

Patients should be engaged in the process of determining the mode of medication delivery (oral vs. intramuscular). If the patient is able to cooperate and there is no contraindication to use, oral medications are preferred over intramuscular ones.

This work group endorses Project BETA recommendations on medication use *(Wilson, 2012)*, however, the implementation of these may be facility and situation dependent. Therefore, the work group believes that the individual organizations should have the flexibility in how they implement these recommendations.

Please see Project BETA Recommendations *(Wilson, 2012)* for full discussion on medication use, including medication table and algorithm for pharmacologic management. The document provides treatment protocols for agitation associated with delirium, agitation due to intoxication, agitation with psychosis in patient with known psychiatric disorder, and undifferentiated agitation.

Since the Project BETA 2012 guideline, a 2016 systematic review by Korczak et al (2016) was published looking at medication used to sedate agitation in patients in the emergency department. It included seven studies with 1,135 patients; reason for patient agitation was not reported *(Korczak, 2016)*. Conclusions:

- **Need for repeat sedation:**
  - Four studies were included in the analysis comparing the need for repeat sedation between antipsychotics and benzodiazepines. Antipsychotics were found to be more effective, as fewer repeat doses needed to be given.
  - When benzodiazepines were compared with combination therapy (antipsychotics and benzodiazepines), two studies showed that combination therapy requires less repeat sedation than when benzodiazepines were given alone.
  - Antipsychotics were compared with combination therapy in only one study and not analyzed further.
- **Adverse events:** Benzodiazepines were more likely to lead to adverse events, primarily involving the respiratory system.

QI: What are the organizational policies and procedures around giving medication for agitated patients? Do these need to be updated to reflect current evidence? Do these encourage patient choice, where possible?

Red Zone (Management of Escalated Agitation)

1. Team Response & Safety Precautions

For a patient with escalating agitation, aggression or violent behavior, additional staff may be needed. Often this may happen in the form of a "code," where additional staff from the ED or elsewhere in the hospital may assist. Safety precautions, as outlined above for agitated patients, should be put in place if not already done so.

Project BETA guidance: *(Richmond, 2012)*

- Important to differentiate between different types of aggression (instrumental or non-emotional, using threat of violence to get what one wants, fear-driven, irritable which can be either chronically angry patients or patients who have had boundaries violated) and apply appropriate de-escalation interventions based on type. Detailed explanation of aggression types and interventions can be found in Richmond et al (2012).
- Patients that do not respond to de-escalation interventions may need to be restrained, if escalate to violence.

QI: How does our behavioral health 'code' team operate? What works well and what needs improvement? Are all on the team trained in assessing aggression types and using appropriate techniques? How are team members quickly briefed before engaging with the patient?

2. Assess and Manage Underlying Etiology

If patient presents in the red zone with escalating agitation and threat of aggression, then assessment and management of underlying etiology should be done. See details in yellow zone. This assessment and management may warrant repeating if patient's agitation is worsening.

3. Verbal and Non-Verbal De-Escalation

See details in yellow zone on guidance for verbal and non-verbal de-escalation.

4. Seclusions and Restraints

These interventions should be used as a last resort. There are multiple potential implications for both patients and staff including, increased likelihood of patient disengagement and lessened success of forming a collaborative relationship, increased incidence of injury (physical and psychological) to both patients and staff, psychological distress, safety and adverse events of medications, and financial and legal consequences for health care organizations *(Knox, 2012)*.

In general, use of forced restraints and seclusions is regulated by the Centers for Medicare and Medicaid Services (CMS) and health care organizations are legally mandated to follow and incorporate CMS guidelines into their policies and procedures. These policies should consider patient rights and legal implications of use of restraints and seclusions. The regulations also include requirements for staff training on verbal de-escalation, management of aggressive behavior and types of restraints that may be used or how to apply them *(Knox, 2012)*. Organizations should be up to date on the latest CMS regulations and state and national laws and adjust their policies and procedures accordingly.

The goal for every organization should be to reduce the use of forced seclusions and restraints. According to Project BETA, the following approaches to achieve this goal may be used: *(Knox, 2012)*

Note: Italicized copy is directly from Project BETA.

- *Change in organization culture where restraint is viewed as a treatment failure*
- *Implementation of an administrative quality management review process aimed at improving outcomes in managing aggressive behavior*
- *Regular staff feedback*
- *Early identification and intervention using de-escalation techniques, and*
- *The use of protocols or aggressive management algorithms to guide clinical interventions.*

CMS has adopted the following definitions for restraints and seclusions: *(Knox, 2012)*

- *Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.*
- *A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.*
- *A drug is considered a restraint when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.*
- *Seclusion and restraint must be discontinued at the earliest possible time.*
- *Within 1 hour of the seclusion or restraint, a patient must be evaluated face-to-face by a physician or other licensed independent practitioner or by a registered nurse or physician assistant who has met specified training requirements.*

Specific to patient 's rights: *(Knox, 2012)*

- *Seclusion or restraint may be used only when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.*
- *All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.*
- *Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others.*

Project BETA guidelines on the use of seclusions or restraints: *(Knox, 2012)*

- *The least restrictive intervention should be chosen and the goal of treatment is to minimize time in forced seclusion or restraint.*
- *For patients who are not actively violent, start with verbal de-escalation. If medication is offered, try to involve patients in decision making on medications.*
- *If the patient is not a danger to others, seclusion should be considered. However, if the patient would be a danger to himself while in seclusion, restraint is appropriate.*
- *If the patient is an immediate danger to others, restraint is indicated.*

- *If the restrained patient will engage in a reasonable dialog, verbal de-escalation efforts should continue, including getting the patient's input on medication. Either way, medication should be administered to calm a patient who has been placed in restraints.*
- *A quiet, unlocked seclusion room should be used if restraint is not indicated and the patient is willing to sit; if not, then forced seclusion is indicated.*
- *Seclusion with decreased stimulation may help some patients regain control while others may need a combination of ongoing verbal de-escalation and medications.*
- *All patients in restraint or seclusion should be monitored to assess response to medication and to prevent complications from these interventions.*
- *When the patient has regained control, a more thorough evaluation can be done, followed by further treatment planning and determining disposition.*

Disposition

1. Appropriate Level of Care

Considerations for moving patients to different levels of care:

- Determine which patients are appropriate for inpatient psychiatric admission vs. discharge to the community. Refer to the MN Health Collaborative recommendations on Medical Clearance and Suicide Prevention and Intervention in the ED on possible guidance.
- Group home patients – can they go back or do they need to move to a different care setting?
- Which patients may be safely discharged home?
- EmPATH and other types of observational units – is it possible to hold patients there until a spot in the community becomes available?
- Be aware of all the resources in the community.
- Continue to build partnerships with mental health and other community resources, where these are available.

QI: What are our three biggest challenges in disposition? What knowledge or relationships do we need to address these challenges?

2. Hand-offs and Documentation

Warm handoffs are critical for a patient with agitation. Standardized questions may help with intra- and inter-organizational communication.

QI: What information is critical in a handoff? How can the patient's behavior during their time in the ED be helpfully summarized (e.g., What de-escalation techniques were effective)? What needs to be documented in the chart?

References

Project BETA for Adults:

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