

TALK DOWN BEFORE TAKE DOWN

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Purpose

The aim of this evidence based project is to reduce behavioral restraint application when managing an aggressive and potentially violent patient in an urban emergency department. Through implementation of a de-escalation checklist and a one-on-one de-escalation interview it is thought behavioral restraint application will be reduced.

Background

Physically restraining aggressive or potentially violent patients can be traumatic and dangerous for patient, family, and healthcare staff. Research suggests one-on-one de-escalation techniques by caregivers can reduce the use of physical restraints when caring for this patient population. Furthermore, recent research suggests the implementation of a checklist in healthcare can increase consistency in care and utilization of evidence based interventions. Through chart review and direct observation in an urban emergency department, de-escalation techniques were not consistently used during encounters with an aggressive or potentially violent patient and rarely were de-escalation techniques addressed in nurse's charting. During a three month period 12 patients were placed in behavioral restraints and de-escalation was attempted only twice.

Methods

A checklist encouraging specific de-escalation techniques and a five minute one-on-one interview was introduced to nursing staff in a 29 bed urban emergency department. The staff received training for the checklist through group huddles and individual discussions. In addition, every year all staff watches a 15 minute video on managing an aggressive or potentially violent person. Reminders of the "Talk Down Before Take Down" program were placed in each nursing station and the checklist was placed with all current behavioral restraint paperwork. Staff was instructed to return completed checklists to a designated spot. On going chart and completed checklist review along with discussions regarding staff satisfaction are being used to assess progress of intervention.

Results

Since implementation of the interventions, the checklist has been utilized once for an aggressive patient and restraints were avoided. One patient was placed in behavioral restraints. The checklist was not used and de-escalation attempts were not documented in the patient chart. In later discussion with staff, de-escalation techniques were

attempted and unsuccessful to calm the patient. The nursing staff stated time constraints prevented checklist completion.

Discussion

Although more time is needed to truly assess intervention effectiveness, it appears there is some resistance from staff in implementing a de-escalation checklist and interview. It is unclear if this is due to lack of skill or knowledge regarding de-escalation techniques or possibly the interventions are perceived by staff as ineffective. Current research suggests in-depth 4 to 8 hour de-escalation and violence management training can reduce behavioral restraint use. In addition, de-escalation techniques, although used by most facilities, are often perceived as ineffective.

Implications

It seems the implementation of a de-escalation checklist and one-on-one interview alone may not be the most effective way to reduce restraint use in an urban emergency department, but these interventions in conjunction with more extensive training may be an effective intervention to reduce behavioral restraint application.

Key words: de-escalation, emergency department, physical restraint use