Objectives
1. Identify important components of a de-escalation management training program for staff who work with psychiatric patients.
2. Distinguish crucial components of a department wide practice change/quality improvement project.
3. Describe staff attitudes and how they may impact violence and aggression with psychiatric patients.

Content Outline:
I. Problem
   A. Violence and Aggression towards Psych Nurses
   B. Restraint Reduction
   C. Challenges in Evaluating Training Programs
II. Background
III. Exploring De-Escalation Management Training Programs
**Problem**

- Psychiatric nurses report some of the highest levels of workplace violence (Gerberich et al., 2004; Lehmann, McCormack, & Kizer, 1999)
  - Role of the RN to maintain safety (self-inflicted, other patients, & staff)
- Roadblocks to examining causes of violence and effective interventions (Morrison & Corney Love, 2003)
  - Lack of “coherent body of evidence-based knowledge upon which to base future violence and restraint reduction efforts (Beech & Leather, 2006; Delaney, 2006; Duxbury & Patterson, 2003)” (Johnson, 2010)

**Problem**

- Movement to decrease patient restraints
  - Obligation to use least restrictive interventions (Moylan & Cullinan, 2011)
  - APNA (2014) & NASMHPD (2001) call to safely eliminate restraints
  - With decreased restraints, injuries have increased (Moylan & Cullinan, 2011)
  - Lack of evidence supporting a universal approach to training nursing staff to maintain safety AND reduce restraints

**Background**

- Major academic medical center
  - 4 inpatient units and 2 outpatient programs
  - 60 room ED with 3 psych beds
  - Child-adolescent, adult, and geriatric populations
- Four hour home grown program
  - Often referred to as “take down & holds”
  - Psych and security staff trained together
  - Need to select a formal de-escalation training program that fits medical center values
  - Need to decrease restraint use department wide
Existing Literature

- Johnson (2010) – Integrative Review
  - 46 papers on research and QI projects aimed to reduce either violence/aggression or restraints/sedation
- Valenkamp, Delaney, & Verheij (2014) – Review
  - 3 papers on empirical studies conducted on interventions to reduce restraints with children and adolescents that had a pre/post test design
  - 2 models identified: Collaborative Problem Solving & Comprehensive Behavioral Management
  - Evaluated 4 commonly used programs: The Mandt System; Nonviolent Crises Intervention (CPI); Professional Assault Response Training (ProACT); Therapeutic Options

ProACT®
Where Safety, Dignity, & Respect Come Together

- Offers a framework of principles
  - Human rights of patients
- Systematic approach to intervention
  - Professionalism & Team Approach
  - Assessment & Problem-Solving (Treatment Planning)
  - Crisis Communication
  - Evasion

http://www.proacttraining.com/about/pro-act-is-principles-not-techniques/

Implementation

- Selection of program – buy-in from multiple departments
- Collaboration with Dr. Mary Johnson
- IRB Approval for collection of data
- Conflict & Containment data collected on 2 inpatient units – 1 month prior to training
- Training of the trainers (Psych, ED, Security, Med-Surg)
  - June 2013
- Roll out of training – year long process started Aug 2013
  - Mixed group of trainers and trainees
  - Psych leadership presence at trainings for support
- Ongoing Trainer Roundtables
- Ongoing data collection
Variables

- Staff attitudes pre- and post-training over first year
  - The Management of Aggression and Violence Attitude Scale (MAVAS; Duxbury, 2003; Duxbury & Whittington, 2005)
- Conflict & Containment Measures on 2 of 4 Inpatient Units
  - Conflict & Containment (Bowers, 2006; Bowers, 2009)
- Restraint and seclusion rates
- Staff and patient injuries

Changes in Attitudes

- Pre- N=150 (100% response); Post N=137 (91% response)
- Significant Overall Change in Attitude F (1, 283) = 18.14, p<.00
- 14 items had significant changes in a favorable direction (p<.05)
  1. aggressive because of the environment
  2. other people
  3. staff do not listen to them
  4. poor communication
  5. 10. seclusion is one of the most effective approaches
  6. 11. often restrained for their own safety
  7. 14. will calm down automatically if left alone
  8. 15. use of negotiation could be used more effectively
  9. 16. restrictive care environments can contribute
  10. 17. do not always require staff intervention
  11. 18. restraint is sometimes used more than necessary
  12. 23. largely situations that contribute
  13. 24. seclusion is sometimes used more than necessary
  14. 27. physical environment were different

Restraints, Seclusion, Conflict & Containment

- Restraints & Seduction for Inpatient units (HBIPS-2 & 3)

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- Highest Incidence of Conflict & Containment before Training (Adult & Gero)
  - Verbal aggression (Both Units)
  - Demanding PRN (Adult Unit)
  - Physical aggression towards others (Gero Unit)
- Overall both patient and staff injuries decreased
Conclusions

- Scheduling staff (both trainers and trainees) can be tricky
- Long process to train entire department and keep units open
- Significant changes occurred when an entire team was trained (outpatient setting trained together and saw immediate decreases) – ongoing tracking continues
- Collection of data on the units may be inconsistent but raises awareness
- Staff attitudes can change
- Need to offer continued support and opportunity for discussion during a culture change

References

- NASMHPD (2001). Reducing the use of seclusion and restraint PART II: Findings, principles, and recommendations for special needs populations.