Acute Behavioural Disturbance

Keeping it Safe in the ED

Tracy Muscat
Nurse Manager - Emergency

Continuing the Mission of the Sisters of the Little Company of Mary
• Level 5 Emergency Department
• 34,000 presentations per annum
• Tertiary Referral Facility
  – Hematology
  – Oncology
  – Toxicology
• Co-located Campus with HNE Mental Health Facility
Isbister G et al.
“Randomized Controlled Trial of Intramuscular Droperidol Versus Midazolam for Violence and Acute Behavioural Disturbance: The DORM Study.” Annals of Emergency Medicine, 2010; 56 (4): 392-401

Calver L et al.

Isbister G, Claver L, Downes M and Page C.
Data sources from security / switch calls
IMMS Aggression incidents in Emergency
(age break down)

Sources 2013 – 2015 IMMS data Aggression incidents
Managing Acute Behavioural Disturbance is Risky Business
Good Practices Reduce the Risks in the management of ABD

- Environment and Design
- Clinical Decision (guidelines / assessments)
- Equipment
- Staff Training
- Processes & Relationships

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Acute Behavioural Disturbance Guidelines

- Clinical approach
- Drug choice
- Assessment tools, screening and Pathway
- Monitoring
ENVIRONMENT AND DESIGN

- Design best practice and principles - not always available within existing builds
- Team Modeling - Using the area you have ABD
  - Space
  - Escape route
  - Number of staff

Seclusion Room?
Resuscitation Bay – Yes
ED equipment is assessed around safety in consideration for high risk patients

- Beds - fitted out with adjustable manual restrain points
- Restraints are routinely checked
- Manual restraint bed always prepared
- IM Retractable needles
- Duress Alarms
PROCESSSES AND RELATIONSHIPS

Code Black
Restraint
Patient Management Plans
Reporting
Code Black

- Low Threshold for calling Code black
- Clear roles members of the code black team
- Team leader - senior nursing / Medical clinician
- ED Nurses do not “take down”
- Application of restraints and administer medication - Manage head / neck

Restraint  *If required*

- Manual until chemical sedation is achieved
- Clinical management - Always managed initially in resuscitation Bay,
Patient Management Plans

• Individual patient plans for known high risk presenters with ABD
• Any staff member can “trigger” a request to consider a plan
• Management process to ensure a Management Plan is warranted and appropriate
• Available electronically and reviewed regularly

Reporting

• Reporting culture
• How to improve reporting IMMS – role of security
STAFF TRAINING

- Orientation & Education
- Training
- Skill development /Competency
- Workforce Planning
- Staff Wellbeing
STAFF TRAINING

• De-escalation Training

• Non violent crisis intervention

• Trainer experienced in Emergency

• Restraint Application

Box 2
De-escalation

- Use an empathic non-confrontational approach, but set boundaries
- Listen to the patient, but avoid giving opinions on issues and grievances beyond your control
- Offer food, drink and a place to sit
- Avoid excessive stimulation
- Avoid aggressive postures and prolonged eye contact
- Recruit family, friends, case managers to help
- Address medical issues especially pain and discomfort
- Try to ascertain what the patient actually wants and the level of urgency

Managing aggressive and violent patients
Australian Prescriber 2011;34:115-8 | 1 August 2011 |
http://dx.doi.org/10.18773/austprescr.2011.061
Gordian Fulde, and Paul Preisz,
Workforce Planning

- Cross Training
- Skill Mix
Where to next...

• Work with MH facility to use the secure hold for the ambulance /police arrival of emergency patients with severe ABD.

• De escalation - Simulation training

• > 65yrs Challenge - any volunteers?
Key Messages

• Management of ABD in ED is Risky Business
• Good Practices Reduces Risk
• Safety First
• Preparation
• Practice
• Planning