De-escalation skills for nurses.

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The de-escalation of a patient or family member becoming aggressive within the hospital setting is perhaps one of the most challenging situations we will encounter as nurses.

It takes a disciplined clinician with good communication skills and strong sense of self-awareness to manage any personal provocation, emotional challenges and professional deprecation that often accompanies such encounters.

The most effective de-escalators have been found to have the following skills:

- Honesty.
- Confidence.
- Non-judgemental.
- A permissive non-authoritarian manner.
- Ability to empathise.

This is all easier said than done.

I am going to give you some practical tips and strategies to manage an aggressive person within the hospital setting.
Think of your response-ability as a skill that you can develop and improve with reflection and mental rehearsal just as with any other emergency scenario.

To be clear, I am talking here about a situation that has not yet become physically violent. It may simply be an angry relative using a raised voice, through to a patient using aggressive body posturing and verbal intimidation.

I am also not talking about a situation where the escalating person has, for example, dementia, or delirium. These situations require an even more specialised set of skills.

Call for help:

Never attempt to de-escalate a potentially violent situation without first making sure your colleagues are aware of what is going on.
And although this is not always possible… preferably only after having discussed a team plan to manage the situation.

If the escalating situation has involved another member of staff it is often useful for a '3rd person' who has not been emotionally involved up until now to take over the de-escalation. The original staff member can be completely removed from the scene (and de-briefed).

If a code has been activated to call security or 'muscle' (sometimes known as a code black), an immediate show of force may escalate and inflame a situation that could otherwise be de-escalated.
The response team should be present but not necessarily have presence.

First: de-escalate yourself.

The first thing to do is to realise you are now actively managing a situation of escalating agitation or violence. The outcome of this situation will have a great deal to do with your own emotional state.

Take a deep breath down into your abdomen and let that initial surge of fight-or-flight energy dissipate (well, at least a little).
When you are feeling really anxious or frightened (which is completely appropriate) it is important to remain calm.
Even more importantly, you must be able to recognise any slide into emotional *reactivity* (rather than *response*) such as becoming argumentative, defensive or aggressive.

Remember, you are not going to *react* to this situation, but rather *respond* with a particular set of skills and strategies to help support and recover the person from their heightened agitated state.

Focus on your environment.
Turn on your situational awareness.

Immediately assess any potential issues in the immediate physical environment. These may include things such as:

Other people. People not directly involved in the de-escalation of this situation should be removed (by other team members) from the immediate area if possible. The obvious reason for this is to maintain their own safety. But it may also help remove any feelings of ‘losing face’ that the person being de-escalated may experience in front of them.

If the person has friends with them they should also *probably* be moved. Occasionally they may have a positive calming influence on the person, but often as they try to help, they confuse the de-escalation process by over stimulating or adding to information overload.

There should only be one primary person communicating with the person being de-escalated.

Physical objects. Are there any physical objects (such as pens, or medical equipment, or furniture) that may potentially become weapons.

Physical space. Take note of the layout of the environment.
There are two important things you need to be mindful of here:

- A path of egress for you. You must *always* have a clear pathway of retreat or exit from the person you are de-escalating. Never let this person come between you and that pathway.
- Choke points for the person being de-escalated. You may or may not wish the person to have a clear exit pathway but be aware of any potential locations where the person may feel he is becoming trapped.

Body Skills:

Physically step back Whist managing an agitated or aggressive person you must maintain at least 2 arm lengths distance at all times.
This will give you enough space to move out of the way if the patient strikes out.
If at any time the person moves towards you or says anything like “get out of my way”, immediately withdraw. Do not attempt to single handedly block or restrain the person.

Having said that, there *may* be a situation where moving in and touching the person may effectively de-escalate the situation. The decision to do this should be made carefully as it may be perceived as a threat and could place you in immediate danger.

Around 90% of all emotional information and 50% of spoken information is communicated by your body language.

Assume a relaxed, open stance. Be ready to move if the need arises.
Your hands should remain visible and not clenched.

Face your body slightly at an angle to the person. This appears less confrontational. Closed body language such as folding arms across your chest or holding a clip-board or other object in front of you may convey aggression or lack of interest.

Try and relax your face. You should make frequent eye contact but do not stare. Again, direct prolonged eye contact may be perceived as aggressive behaviour.

Verbal Skills:

People who are aroused and agitated may have difficulty processing verbal information. So, the key points here are:

- Be authentic.
- Be concise.
- Keep it simple.
- Repeat it as necessary.
- Be prepared to listen twice as much as you talk.

If the person does not yet know you, begin by introducing yourself. Ask the person how he prefers to be addressed.

Whatever you are going to say, you need to try to be authentic.
Being present with a calm authenticity communicates to the patient that despite their anger and aggression you are trusting them not to be physically violent.

Your voice should be clear with a soft tone.
When giving information you should use a simple, concise language.

During your interaction you may need to make a request, or set a boundary, or offer alternatives. The person may at first remain disengaged or uncooperative.
An essential tip is not to shut down any further conversation at this time. The information may need to be repeated several times before it is actually processed.

Try to get the person to verbalise their wants and their feelings.
This is an important part of getting *them* to tune in and engage.

They may wish to vent their anger, or request medication or want to see somebody ‘in-charge’.
A good statement might go something like:
“I really need to know what you want right now. Even if I cannot provide it, I would like to know so we can work on it”

Sometimes it may be appropriate to tell the person they are making you feel afraid or uncomfortable (if this is the case) and that this will make it difficult for you to help.

“Please I would really like you to sit down. Right now, you are really making me feel frightened for my safety and I can’t concentrate on what you are saying. Please, let’s calmly go through your concerns so I can understand you.”

Sometimes the use of humour may help de-escalate the situation.
The decision to use humour must be made carefully for there is a risk that the person will feel you are being condescending or belittling.

Listening skills:

It is important to try and really understand what another person is saying without colouring it with our own interpretations or agendas.

To help you do this, you might like to remember Millers Law:

“To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of.”
– George Miller https://en.wikipedia.org/wiki/Miller%27s_law

You might need to read that twice and have a think about it. But essentially it is asking you to acknowledge that everyone has their own truth, and instead of trying to bring someone from *theirs* to *yours*, better communication occurs when you look for a place where those truths overlay, or at least touch up against each other.
This is a space you can work from.

Even if the person is obviously (to you) deluded or wrong, you might imagine *how* this is true for them and guide the conversation to explore this.
If there is no way you can find a way to agree with the persons point of view, or delusion, you *can* acknowledge that you believe they are having that experience.
And….you can simply agree to disagree.

Set boundaries:

It is important in any situation of escalating violence to set clear and defined boundaries.
These boundaries should be set early but not thrown out as threats or as a 'show of power'.
Instead, use them as appropriate during the conversation.

The most important boundaries to be set is that of physical violence.
Tell the person that any physical violence towards you, themselves, or anyone else is unacceptable.
The first sign of this will end all further conversation and they may be arrested and prosecuted.

Again, these limits must be presented with care. They are not verbal weapons to give you the upper hand, but clear guidelines to help the person modulate their behaviour. They may need to be repeated multiple times and should always be presented with respect to the persons dignity.
Often aggression is simply a response to feelings of lost dignity and feeling respected will help dissipate these feelings of anger.

Into the RED zone.

If the situation continues to escalate, consider your options:

- Give the person options other than violence. What can you realistically offer the person that may help them calm down without losing face?

- Medication may be used to help calm (never say sedate) the person and could be offered.
- Withdraw from further attempts at de-escalation.

At this point communication shifts from discussing the persons feelings, or actively listening, or working towards solutions to a much more authoritative approach. There are some excellent resources on this topic here: https://intensivecarenetwork.com/disruption-danger-droperidol-emergency-management-agitated-patient/

The focus is now on ensuring everyone's safety. Including the person escalating.
It may require chemical or physical restraint.
It may require escorting the person to a safer environment or even removing them from the hospital grounds.
It should involve a rapid co-ordinated response from the hospital 'code black' team or the police.

The need to switch to this authoritative approach should be anticipated and prepared for by staff supporting the de-escalation attempts up to this point. For example, staff may have made a decision to call police or prepare the code black team as they assess the unfolding scenario. Once it becomes apparent that de-escalation is not going to be effective a smooth transition from de-escalation to de-fusing the situation can be made.

Document and de-brief.

The importance of contemporaneous and accurate documentation of the escalation and response cannot be overemphasised. Especially if the event included physical restraint of any kind.

As always there should be some form of informal de-brief amongst team members involved and an opportunity for professional counselling offered if it is required.

References:

Featured image by Craig Sunter
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