AGGRESSIVE BEHAVIOUR PREVENTION AND MANAGEMENT IN THE INTENSIVE CARE UNIT ST GEORGE HOSPITAL

| Cross References (including NSW Health/ SESLHD policy directives) | NSW PD 2005_315 Zero Tolerance Response to Violence in the NSW Health
| | SESLHD PD 110 Security Physical Response
| | SESLHD PD 111 Restraint Policy – use of (Adult Patient)

1. What it is
To provide a framework for the early identification and management of patients at risk of aggressive behaviour, to prevent the escalation of aggressive behaviour and to ensure a standardised documented management plan ensuring the safety of all patients, visitors and staff within the St George Hospital Intensive Care Unit (STG ICU).

This document collaborates:
- A two stage preventative process:
  - Aggressive Behaviour Screening Guide
  - Patient Management Planning and Documentation
- A single stage intervention process:
  - Aggressive Patient Pathway

2. Risk Rating
Moderate

3. Employees it applies to
All staff who work within the St George Hospital Intensive Care Unit.

4. Process Definitions
Aggression is defined as feelings of anger, hostile or violent behaviour toward another, readiness to attack or confront. Patients who are more likely to show signs of aggression (based on a review of incidences) are male, less than 65 years of age, past history of aggressive behaviour, drug and/or alcohol use and/or patients suffering mental health conditions.

- Aggressive Behaviour Screening Guide– To be completed on the admission of every patient (*Appendix 1*)
- Aggressive Patient Management Template – To be completed if the screening guide suggests the patient is a potential aggression risk (*Appendix 2*)
- Aggressive Patient Pathway – to be instituted if a patient shows signs of aggressive behaviour (*Appendix 3*)

The Intervention stages should NOT be implemented if the preventative process has not identified the patient as appropriate for this Clinical Business Rule. Patients excluded from this business rule include (but are not limited to) those with aggression secondary to dementia for example.

There is a 2 step process for identification, documentation and management of the aggressive behaviour in the ICU.
4.1 PREVENTION AND RISK MANAGEMENT

4.1.1 Aggressive Behaviour Screening Guide
The assessment guide will be used to assess all patients admitted to STG ICU. It is the responsibility of the ICU Registered Nurse (RN) caring for the patient to complete the screening guide. If the result of this screening is that the patient is at risk of displaying aggressive behaviour, it is the responsibility of the ICU RN to notify the NUM / In-Charge of the shift and ICU medical team.

The Aggressive Behaviour Screening Guide is located on the STG ICU Clinical Information System (CIS) and documentation of the score will be included in the patient’s clinical notes. (Appendix One)

4.1.2 Aggressive Patient Management Template
If a patient is identified as being at risk of displaying aggressive behaviour. A management plan will be documented on patient’s admission to the ICU. The documentation template located in the STG ICU CIS is to be used by the ICU Admitting Medical Officer to document the perceived risk factors, mental health team involvement and proposed pharmacological management of each patient who is deemed to have a potential for aggressive behaviour.

The management plan will be updated and revised by the ICU medical team when there is a change to a patient’s clinical condition and care plan. (Appendix Two)

4.2 INTERVENTION

4.2.1 Aggressive Patient Pathway
There are four stages to the Aggressive Patient Pathway:
1. Stage One – De-escalation Stage  Perceived Risk of Harm is Low.
2. Stage Two – Planning Stage  Perceived Risk of Harm is Moderate.
3. Stage Three – Restraint Stage  Perceived Risk of Harm is High.

The Aggressive Patient Pathway will be used when interacting with a patient showing signs of aggressive behaviour. It provides specific instructions based on escalating behaviours and the maintenance of patient and staff safety. This flow chart is accessible via the CIS. (Appendix Three)

- Stage Three of Aggressive Patient Pathway – Duress Alarm Activation
If the situation escalates (stage three) and further assistance is required to maintain safety activation of the Duress is required. There are three duress alarms in the ICU, one above the intercom, one under the ward clerk’s desk and another on the wall opposite bed 11. These are silent alarms and are activated using the red buttons on the underside of the box. The duress alarm display screen should be green at all times and will change to red once activated. Once activated, the alarms need to be reset by security. (Appendix Four)

- Stage Three of Aggressive Patient Pathway – Restraint

If de-escalation strategies (Appendix 3) have been unsuccessful (stage one) and the planning stage has been completed (stage two). It will be necessary to utilise a method of restraint to ensure patient and ICU staff safety.
- **Physical Restraint**
  It is the responsibility of the ICU RN to notify the NUM / In-charge and ICU team when a patient’s behaviour has escalated. The ICU medical staff will order the restraint (in line with the SESLHD PD) of a patient to prevent harm to self and others. As per SESLHD PD 111 Restraint Policy, observations of the restraints and skin must be attended and documented every 15 minutes.

- **Pharmacological Restraint**:
  Preventative - Administration of medication may be required to ensure the safety of a patient and the ICU staff. Some patients may require the institution of Benzodiazepines prior to the cessation of sedation in preparing for extubation and they are likely to (or have previously) shown risk of harming themselves or members of the ICU team. The medical team should also consider whether it would be appropriate to recommence any of the patients’ normal medications which could aid in their emergence.

  Acute - Stage three of the Aggressive Patient Pathway calls for firstly physical restraint followed by pharmacological restraint.

  Guidance on the appropriate dose may be obtained using the Pharmacological Administration Table for the Aggressive ICU Patient which can be found in table format on the CIS.(Appendix Five).

  Intravenous (IV) access may be removed for the safety of the patient and ICU staff.

  If the patient has pre-existing IV access – the IV medication table should be used. If not, the IM medication table should be used.

  Once pharmacological restraint is instituted the patient should be recommenced/continue on cardiac monitoring with ongoing assessment of the Glasgow Coma Scale (GCS), Richmond Agitation Sedation Scale (RASS) and all other ICU observations.

  The prescribing medical officer should document an ideal RASS score and the RN should endeavour to achieve this. If this is unable to be achieved, the medical staff should be immediately notified.

4.3 **Discharge of the previously aggressive ICU patient**

When a patient is cleared for discharge from the ICU, documentation of the management of the aggressive behaviour must be included in the medical discharge summary. The ICU Nurse In-charge may deem it necessary that an alert be added to the patients eMR file. This alert should be attached using a non-biased, objective clinical judgment.

When a patient is for discharge to another unit/ward and continues to display aggressive behaviour, appropriate verbal handover should be given to both the appropriate medical and nursing staff.
### St George Hospital Intensive Care Unit - Aggressive Behaviour Screening Guide

<table>
<thead>
<tr>
<th>List A - Observational</th>
<th>List B - History</th>
<th>List C – Medical Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a known history of drug or alcohol misuse? ☐</td>
<td>Is there are known history of threatening or aggressive behaviour? ☐</td>
<td>Has the patient had a medical diagnosis of any of the following:</td>
</tr>
<tr>
<td>Do the patient’s family/friends feel that the patient could display aggressive behaviour? ☐</td>
<td>Has the patient assaulted (physically or verbally) any members of the health care profession in the past 12 months? ☐</td>
<td>Traumatic Brain Injury ☐</td>
</tr>
<tr>
<td>Is the patient displaying two or more of the following: confused, disorientated, delirious, hallucinating? ☐</td>
<td>Has the patient made any threats of aggression directed at people or property? ☐</td>
<td>Organic Brain Dysfunction ☐</td>
</tr>
<tr>
<td>Does the patient appear restless or agitated? ☐</td>
<td></td>
<td>Hypoxic Brain Injury ☐</td>
</tr>
</tbody>
</table>

**List A:**
Two or more YES responses in LIST A = potential aggression risk.

**List B:**
One or more YES responses in LIST B = potential aggression risk.

**List C:**
One or more YES responses in LIST C = potential aggression risk.

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APPENDIX TWO

Aggressive Patient Management Template

Patient identified as having a potential risk of aggression. An AWS should be conducted __ hourly.

Perceived factors that lead to potential risk include:
(delete non-applicable points, add other perceived risk factors)
• Toxicology screen results
• Elevated ethanol level
• Aggressive behaviour documented in patient’s notes prior to ICU admission (expand)
• Noted past history of aggression

Mental health team notification:
Dr. ______ notified of patients admission (time/date).
***Note: if referral to Mental Health Team was made afterhours/on a weekend, another referral must be made at the next opening of business***

PRN medications have been prescribed in case de-escalation techniques fail. If given, aim RASS ___ and notify ICU team. OR
PRN medications have not been prescribed because... This will be reviewed as required.

Please remove:
Arterial line
Central line
Peripheral IVC/s
IDC
NGT/OGT

This patient requires a 1:1 nursing ratio until reviewed by the Mental Health Team.

A Schedule 1 or 2 has been completed for this patient on the (date) and (time).

I have notified the NUM/In-charge and the bedside RN of the above.

Highlighted red = unable to be deleted.
Highlighted blue = add and subtract as required
Highlighted green = select one or the other
APPENDIX THREE

The St George Hospital – Intensive Care Unit - Aggressive Patient Management Flow Chart

STAGE ONE
Perceived Risk to Self or Others = LOW

De-escalation Techniques:
- Remain calm
- Listen to patients concerns
- Emphasise desire to help patient
- Try to make patient comfortable and/or utilise patients friends/family if appropriate
- Be aware of body language
- Familiarise yourself with closest duress/nurse call alarm
- Notify ICU in-charge of concerns

STAGE TWO
Perceived Risk to Self or Others = MODERATE

Planning Stage:
- Senior Registrar or Night Duty Registrar assumes the team leader role
- Patient should be assessed
- Establish a management plan, inform bedside nurse of this plan as well as the in-charge nurse
- "Stand-by" call to security
- Schedule if appropriate or review schedule if already in place
- Remove potential dangers from immediate area
- Continue de-escalation techniques

STAGE THREE
Perceived Risk to Self or Others = HIGH

Restraint Stage:
- Duress alarm activation
- In-charge to decided whether it is appropriate to close the unit to visitors
- Appoint scribe
- One person giving instructions whilst patient is being restrained
- Have all necessary equipment/medications are ready
- Close unit to visitors
- Gather appropriate PPE
- On the leaders signal each member assumes their position
- When safe, medication is administered
- Attach monitoring, reposition patient when safe to do so

STAGE FOUR
Perceived Risk to Self or Others = EXTREME

"Code Black"
- A serious threat to the physical well being of staff (eg: weapon, personal threat).
- Call 777
- Police will attend
- Four R’s: Remain calm, Retreat if safe to do so, Raise the alarm and Record details

A debrief of the incident should occur as well the completion of an IEMS if necessary.

Documentation of the incident should be made in the patient’s notes by both medical and nursing staff as soon as possible.

Security Physical Response – Area Directive
Green = Non Activated
Red = Activated

Buttons for activation, push upwards
### APPENDIX FIVE

#### Intravenous Pharmacological Restraint

<table>
<thead>
<tr>
<th>Route</th>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Notes</th>
<th>Caution</th>
</tr>
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<tbody>
<tr>
<td>IV</td>
<td>Diazepam</td>
<td>5mg</td>
<td>Repeated every 3-4 minutes</td>
<td>Titrate to clinical response. Some patients may require larger bolus amounts – 10-20mg. (After discussion with the ICU Senior Registrar)</td>
<td>Respiratory Depression</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(Max. 30mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Midazolam</td>
<td>2.5-5mg</td>
<td>Repeated every 3-4 minutes</td>
<td>Titrate to clinical response. Some patients may require larger bolus amounts – 10-20mg. (After discussion with the ICU Senior Registrar)</td>
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If unable to achieve desired clinical response, Olanzapine or Haloperidol are recommended in conjunction with benzodiazepines.

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<td>IM</td>
<td>Olanzapine</td>
<td>10mg</td>
<td>Once</td>
<td>Longer acting than other anti-psychotic drugs.</td>
<td>If extrapyramidal adverse effects (such as dystonia) occur, anticholinergic drugs should be given.</td>
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Adapted from the e-Therapeutic Guidelines – Behavioural Emergencies – Acute Medical Setting

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5. Keywords
Aggression, Physical Restraint, Pharmacological Restraint

6. Functional Group
ICU

7. External References


Health and Safety Regulation 2011
http://
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<th>8. Consumer Advisory Group (CAG) approval of patient information brochure (or related material)</th>
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<tr>
<td>9. Implementation and Evaluation Plan</td>
<td>Education plan and learning package to assist with aggressive behaviour and de-escalation skill – Julie Cosgrove &amp; Clare Loveday in association with Alison Boyle and ICU NE/CNEs</td>
</tr>
<tr>
<td>Including education, training, clinical notes audit, knowledge evaluation audit etc</td>
<td>Reduction in injuries to staff from aggressive patients, via IIMs notification</td>
</tr>
<tr>
<td>10. Knowledge Evaluation</td>
<td>Q1: When is the Aggressive Behaviour Screen conducted and by who? A: On admission of every patient to the ICU by the admitting Registered Nurse.</td>
</tr>
<tr>
<td></td>
<td>Q2: Who is responsible for the documentation of a management plan if a patient is deemed to be at risk of aggressive behaviour? A: The admitting Intensive Care Medical Officer should use the documentation template on the CIS. This plan should be revised when there is a change in the patient's clinical status or management plan.</td>
</tr>
<tr>
<td></td>
<td>Q3: What is the aim of the Aggressive Patient Flow Chart? A: The aim of the flow chart is to manage a patient’s aggressive behaviour and ideally prevent it escalating. Ultimately, its aim is to ensure the safety of both the patient and ICU staff.</td>
</tr>
<tr>
<td></td>
<td>The effectiveness of these strategies will be reassessed 6 months and 12 months post introduction to evaluate whether they have assisted in creating a standardised response to aggressive behaviours shown by Intensive Care patients. Regular IIMS analysis will also be conducted.</td>
</tr>
<tr>
<td>11. Who is Responsible</td>
<td>ICU Director</td>
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</tbody>
</table>
## Approval for (Insert Clinical Business Rule Title) appropriate

| *Specialty/Department Committee | ICU Nursing Practice  
<table>
<thead>
<tr>
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<tr>
<td>Chairperson name/position: Sarah Jones</td>
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| *Specialty/Department Committee | QA ICU Meeting  
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<tr>
<td>Chairperson name/position: Clare Loveday Manager ICU</td>
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</tbody>
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| *Nursing/Midwifery Co-Director | Julie Cosgrove |

| SGH Drug and Therapeutics Committee | A/Professor Winston Liauw (Chairperson) |

| *Medical Director | A/Professor Theresa Jacques |

| Executive Sponsor | Nicole Wedell A/CGM |

| Contributors to CIBR development  
e.g. CNC, Medical Officers (names and position title/specialty) | Jessica Keady CNS ICU, Kate Powell A/Nurse Manager |

## Revision and approval history

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision number</th>
<th>Author (Position)</th>
<th>Revision due</th>
</tr>
</thead>
</table>
| March 2014 | 0               | Jessica Keady ICU CNS  
Sarah Jones ICU CNC | March 2017 |

## Director of Operations Ratification

Name: Cath Whitehurst  
Date: March 2014