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Disruptive Patient 2: Restraints

Instructor Information

Patient Name: Rolando Jones

Simulation Developer(s): Melissa Brickner, Bridgett Everett, Debra A. Mosley, Beverly Snyder-Desalles, and Judy Young

Scenario Purpose:

- To safely and effectively establish safety for the disruptive inpatient by utilizing restraints as a last resort

Learner(s):

- **Registered Nurses (RN), Licensed Practical Nurses (LPN), Unlicensed Assistive Personnel (UAP)**
- **Others as desired, depending on facility protocols**
- **Recommend no more than 6 learners (3 of which can be observers)**

Time Requirements:

- **Setup:** 5 minutes
- **Scenario:** 25 minutes
- **Debrief:** 25 Minutes
- **Reset/Breakdown:** 5 minutes

Confederate(s):

- **Wife**
- **Assistance (security officer, police, or facility specific)**
- **Standardized patient**

Scenario Prologue:

- The patient is a forty-nine (49) year-old male inpatient admitted with severe lower back pain. The wife is at the bedside. The patient becomes increasingly agitated threatening to injure all present in the room. The application of restraints will be warranted to establish safety.
- **The simulation begins when the learners enter the room**

Patient information:

- ***General:*** Agitated
- ***Weight/Height:*** 113.6kg (250lbs) 182.9 cm (72in)
- ***Vital Signs:*** BP 188/92, Temp 97, HR 140, RR 26, O2 Sat 96%
- ***Pain:*** 6/10 In the lower extremities
- ***Neurological:*** Numbness and pain in bilateral lower extremities
- ***Respiratory:*** Lungs clear, dyspneic, tachypneic
- ***Cardiac:*** Tachycardic
- ***Gastrointestinal:*** Unremarkable
- ***Genitourinary:*** Unremarkable
- ***Musculoskeletal:*** Gait unsteady
- ***Skin:*** Face flushed; cheeks red
- ***Past Medical History:*** Post Traumatic Stress Disorder (PTSD), type 2 diabetes, chronic obstructive pulmonary disease (COPD), arthritis, diabetic neuropathy, 30 year one pack per day smoking history, and he drinks "a few beers a day"
  - ***Past Surgical History:*** Appendectomy and bilateral lower extremity shrapnel removal

Medications:

- Metformin 500 mg three times daily with meals
- Lorazepam 2 mg every 8 hours
- Albuterol/Ipratropium inhaler 2 puffs four times a day
- Gabapentin 300 mg three times daily

Allergies:

- No known drug allergies (NKDA)
- Allergic to dairy products

Confederate

Change in Physiology

Learning Objectives

Patient Name: Rolando Jones
Simulation Developer(s): Melissa Brickner, Bridgett Everett, Debra A. Mosley, Beverly Snyder-Desalles, and Judy Young

Scenario Purpose:

- To safely and effectively establish safety for the disruptive inpatient by utilizing restraints as a last resort

Pre-Session Activities:

- Complete pertinent training on management of the disruptive inpatient
- Review VHA Directives, policies and protocols on management the disruptive inpatient
- Review federal, state, and institutionally specific regulations and protocols regarding the use of physical and chemical restraints
- Review interdisciplinary roles when caring for the disruptive inpatient

Potential Systems Explored:

- What de-escalation techniques are designed for use on the disruptive patient?
- What standardized protocols currently exist to establish safety for the disruptive patient?
- When should the healthcare provider consider chemical or physical restraints?
- Which staff members are qualified to apply physical restraints?
- What facility specific documentation is required when caring for the disruptive patient?
- What risk factors, contraindications, and complications are important to consider when caring for the agitated or disruptive patient?

Scenario Specific Learning Objectives (Knowledge, Skills, and Attitudes = K/S/A):

**The learner(s) will demonstrate ICARE principles throughout the scenario.

Learning Objective 1: Demonstrate the use of Prevention and Management of Disruptive Behavior (PMDB) principles when managing the care a disruptive inpatient

a. ***K***- *Recognize the patient's behavior as Panic Stress level*
   S- *Implement PMDB de-escalation techniques to establish safety*
   A- *Maintain a controlled demeanor throughout the scenario*
b. ***S***- *Remove all unnecessary staff, patients, and visitors from the room*
c. ***S***- *Avoid becoming isolated in the room with the patient*

Learning Objective 2: Implement facility specific protocol when additional assistance is warranted for the inpatient exhibiting escalating disruptive behavior

a. ***S***- *Initiate facility specific protocol to obtain additional assistance*
b. ***K***- *Discuss interdisciplinary resources available*

Learning Objective3: Implement the use of restraints as a last resort for the patient exhibiting escalating disruptive behavior per protocol

a. ***K***- *Consider the use of restraints as a last resort*
   S- *Apply restraints appropriately according to federal, state, facility, and unit protocols*

Learning Objective 4: Utilize effective communication techniques when caring for the disruptive inpatient

a. ***S-*** *Perform ISBAR handoff communication*
b. ***S-*** *Complete facility specific documentation*

Debriefing Overview:

- Ask the learner(s) how they feel after the scenario
- Have the learner(s) provide a summary of the scenario from a healthcare provider/clinical reasoning point of view
- Discuss the scenario and ask the learners what the main issues were from their perspective
- Ask what was managed well and why.

- Ask what they would want to change and why.
- For areas requiring direct feedback, provide relevant knowledge by stating "I noticed you *[behavior]…"* Suggest the behavior they might want to portray next time and provide a rationale. "Can you share with us?"
- Indicate closing of the debriefing but provide learners with an opportunity to voice one or two take-aways that will help them in future practice
- Lastly, ask for any outstanding issues before closing the debrief

Critical Actions/Debriefing Points:

1. Call for additional assistance
2. Recognize the patient's behavior as Panic Stress level
3. Utilize PMDB de-escalation techniques to establish a safe environment
4. Remove all unnecessary staff, patients, and visitors from the room
5. Avoid becoming isolated in the room with the patient
6. Consider chemical or physical restraints per protocol as a last resort
7. Apply physical restraints per protocol
8. Perform ISBAR communication
9. Complete facility specific documentation

Simulation Set-Up

(Standardized Patient)

Patient Name: Rolando Jones
Simulation Developer(s): Melissa Brickner, Bridgett Everett, Debra A. Mosley, Beverly Snyder-Desalles, and Judy Young

Room Set-up:

- Set up like a hospital patient room. The patient is lying in bed with the head of the bed elevated preparing to eat breakfast. The breakfast tray is in front of the patient on the bedside table. There is a container of milk included with the meal on the tray.

Patient Preparation:

- Hospital gown
- Saline lock in the right antecubital space
- Patient identification band indicating allergy to milk
- Ensure wrist restraints are within reach
- Blood pressure cuff is on the patient

Have the following equipment/supplies available:

- Telephone
- Gloves
- Hand sanitizer
- Blood pressure cuff
- Soft wrist restraints
- Meal tray that includes a container of milk

Note: 5.8 Simpad software update is required to load scenarios (http://cdn.laerdal.com/downloads/f4343/simpad-upgrade.vs2
Scenarios may be used with Laerdal or LLEAP software.

Scenario Supplements:

- Confederate scripts
- Confederate and learner name tags
- Information on how to request emergency mental health team assistance
- Patient identification band
- Nurses notes
- Orders
- PMDB supplement
- Code Orange Button picture
- ZZ test patient/Demo patient in CPRS (if desired)

Flowchart

Initial State:
- Mental Status: Tense, agitated
- Blood pressure cuff is attached to the patient
- Pain level: 6/10 lower back
- Skin: Face flushed/cheeks red

The patient is a 49 year old male inpatient becoming increasingly agitated. The on-coming and off-going nurses are conducting their hand-off communication. The wife is at the bedside.

- ***The patient throws his water pitcher and breakfast tray across the room and yells "I'm allergic to milk!!! I've told you for 2 days, I'm allergic to milk!!! Are you trying to kill me???!!***
- ***On-coming nurse and off-going nurse stop their hand off communication***
- ***Patient's wife states "They are not trying to kill you, please try to calm down."***

Status Change
- Mental status: **Patient becomes increasingly agitated**
-RR: **32 Labored**

- ***Patient hastily removes monitor and blood pressure cuff and shoves the wife away from the bed shouting "Leave me alone!"***
- ***Team member(s) recognize this behavior as Panic Stress level***
- ***Calls for additional assistance per facility protocol***

- ***Implements Prevention and Management of Disruptive Behavior (PMDB) De-escalation techniques to establish a safe environment***
- ***Removes all unnecessary staff, patients, and visitors from the room***
- ***Avoids becoming isolated in the room with the patient***

Did not follow PMDB Principles
- **Team member(s) remain isolated in the room with the patient**
- **The door is closed**

- ***The patient becomes increasingly agitated shouting expletives, clenching his fists, lunging towards his wife trying to strike her stating "This is your fault!"***
- ***Considers the use of chemical or physical restraints as a last resort***
- ***Applies restraints for safety per protocol***

Did not apply restraints
- Mental status: **Patient clenches fists, climbs out of the bed and threatens to physically injure all individuals present during the scenario by stating "Don't try me! I will take you all down!"**
-RR: **32 Labored**

Assistance Arrives
- ***Patient states "I am sorry I was getting so upset, it has been so frustrating having to repeat myself so many times about my milk allergy. Can you make sure this is taken care of?"***
- ***Performs ISBAR communication***
- ***Completes facility specific documentation***

Critical Actions/Debriefing Points:
1. Call for additional assistance
2. Recognize the patient's behavior as Panic Stress level
3. Utilize PMDB de-escalation techniques to establish a safe environment
4. Remove all unnecessary staff, patients, and visitors from the room
5. Avoid becoming isolated in the room with the patient
6. Consider chemical or physical restraints per protocol as a last resort
7. Apply physical restraints per protocol
8. Perform ISBAR communication
9. Complete facility specific documentation

Confederate

Red Text Physiology Change

Red Border Incorrect Action

Supplements

Confederate scripts
Confederate and learner name tags
Patient identification band
Nurses notes
Orders
PMDB supplement
Code Orange Button (Call for Assistance)

Confederate Scripts

Rolando Jones: Standardized Patient

Medical/Surgical History: PTSD, type 2 diabetes, COPD, arthritis, diabetic neuropathy, 30 year one pack per day smoking history, and he drinks "a few beers a day." Appendectomy and lower extremity shrapnel removal (Vietnam Vet)

Medications: Metformin 500 mg three times daily with meals

- Lorazepam 2 mg every 8 hours
- Albuterol/Ipratropium inhaler 2 puffs four times a day

Allergies:

- NKDA; Allergic to dairy products
- Throw the water pitcher and breakfast tray across the room and shout "I'm allergic to milk!!! I've told you for 5 days I'm allergic to milk!!! Are you trying to kill me???!!"
- The wife will state "They aren't trying to kill you, please calm down."
- Hastily remove the blood pressure cuff and shove the wife away from the bed shouting "Leave me alone!"
- Become increasingly agitated; shout expletives with clenched fists lunging towards the wife shouting "This is your fault?"
- Continue to threaten the wife until restraints are applied
- If PMBD principles are not followed, clench both fists and threaten to physically injure all present stating "Don't try me! I will take you all down!"
- If PMDB principles are followed, the patient calms down and states "I am sorry I was getting so upset, it has been so frustrating having to repeat myself so many times about my milk allergy. Can you make sure this is taken care of?"

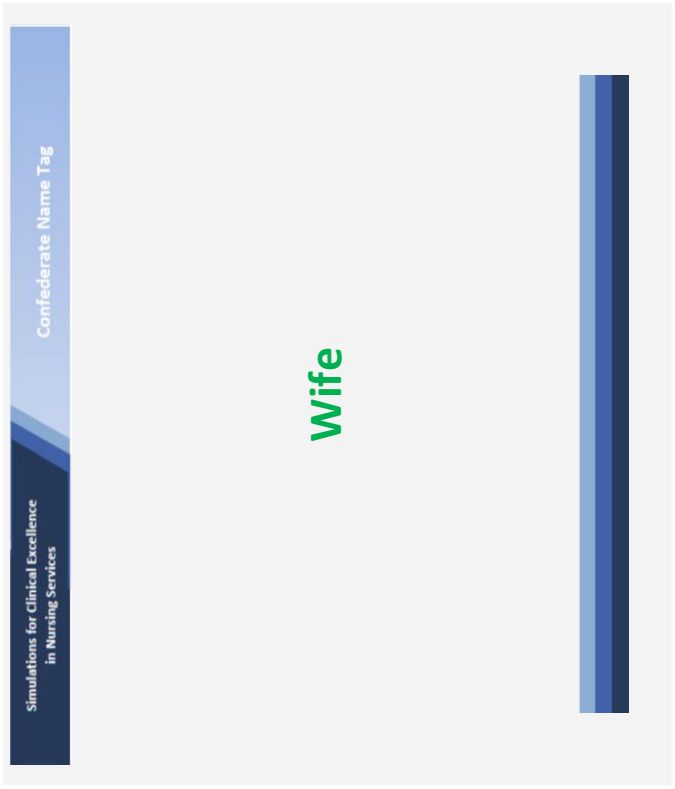
Wife

- The wife is at the patient's bedside trying to calm the patient down
- The patient will state "I'm allergic to milk!!! I've told you for 2 days I'm allergic to milk!!! Are you trying to kill me???!!"
- The wife will tell the patient "They are not trying to kill you, please try to calm down."
- The patient will shove the wife away from him and shout "Leave me alone."
- Insist on remaining in the room with the patient

Assistance

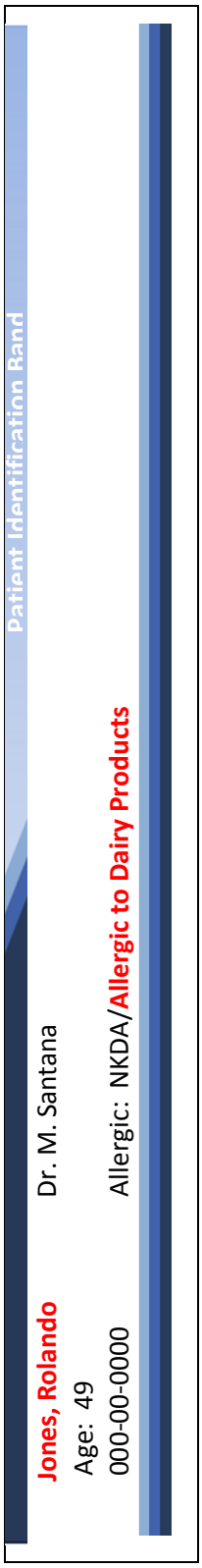
- Assistance arrives right after restraints are applied
- The patient will state "I am sorry I was getting so upset, it has been so frustrating having to repeat myself so many times about my milk allergy. I felt like nobody was paying attention to me. Can you make sure this is in my chart and taken care of?"
- ISBAR will be provided
- End of scenario

Confederate Name Tags



May print multiple ASSISTANCE tags prn

Patient Identification Band



Nurses Notes

Insert picture of patient here

Date: Today
Patient Name: Jones, Rolando
Mode of Arrival: Personally owned vehicle
Accompanied by: Wife (optional)

Chief Complaint: 49 year old male presented with severe lower back pain
Active Problems: Post Traumatic Stress Disorder (PTSD), type 2 diabetes, chronic obstructive pulmonary disease (COPD), arthritis, and diabetic neuropathy, 30 year one pack per day smoking history, and he drinks "a few beers a day"

Patient Information:

- **General:** Agitated
- **Weight/Height:** 113.6kg (250lbs) 182.9 cm (72in)
- **Vital Signs:** BP 188/92, Temp 97, HR 140, RR 26, O2 Sat 96%
- **Pain:** 6/10 In the lower extremities
- **Neurological:** Numbness and pain in bilateral lower extremities
- **Respiratory:** Lungs clear, dyspneic, tachypneic
- **Cardiac:** Tachycardic
- **Gastrointestinal:** Unremarkable
- **Genitourinary:** Unremarkable
- **Musculoskeletal:** Gait unsteady
- **Skin:** Face flushed; cheeks red
- **Past Medical History:** Post Traumatic Stress Disorder (PTSD), type 2 diabetes, chronic obstructive pulmonary disease (COPD), arthritis, diabetic neuropathy, 30 year one pack per day smoking history, and he drinks "a few beers a day"
- **Past Surgical History:** Appendectomy and bilateral lower extremity shrapnel removal

Medications:

- Metformin 500 mg three times daily with meals
- Lorazepam 2 mg every 8 hours
- Albuterol/Ipratropium inhaler 2 puffs four times a day
- Gabapentin 300 mg three times a day

Allergies:

- Dairy products

SCREEN FOR ABUSE/NEGLECT: N/A
Does the patient show any evidence of abuse? No
Does the patient feel safe in his/her current living arrangements? Yes
Suicidal or Homicidal Ideation in the past two weeks? No
Is the patient currently enrolled in primary care? Yes

Diagnostic Procedures Ordered:
( ) X-Ray
( ) Labs
( ) None
( ) EKG
( ) Head CT without contrast
(x) Other-MRI of the lumbar spine

Triage Classification: Emergency Severity Index
Patient Disposition: Medical-Surgical Unit / Bed 1
Signed by: /DM/

Orders

Patient Information

Jones, Rolando
Dr. M. Santana
Age: 49
Social Security #: 000-00-0000
Allergies: Dairy products
Weight: 113.6kg (250lbs)
Height: 182.9 cm (72in); BMI 33.9

Admit to	Medical Surgical unit
Diagnosis	Severe lower back pain
Condition	Stable
Diet	1500 calorie ADA
Activity	Bathroom privileges
IV Therapy	Saline Lock
Medications (routine)	Metformin 500 mg three times daily with meals Lorazepam 2 mg every 8 hours Albuterol/Ipratropium inhaler 2 puffs four times a day Gabapentin 300 mg three times a day
Medications (prn)	Morphine sulfate 5 mg IV every four hours for back pain
Diagnostics	
Fingerstick Blood Sugar	
Code Status	Full code
Respiratory Therapy Orders	N/A
Miscellaneous Orders	Apply wrist restraints for safety per protocol

DO NOT WRITE IN THIS SPACE

Prevention and Management of Disruptive Behavior (PMDB) Supplement

Four Levels of Stress

Stress Level	Signs and Symptoms	Interventions
Normal	• Heart rate 60-80 bpm • Keen awareness of surroundings • Thinking and processing information clearly	Offer the patient assistance and provide good customer service by responding promptly in a professional and respectful manner. Escalation may be avoided simply by communicating any anticipated or current plans of care.
Moderate	• Heart rate 81-100 bpm • Perceptual field decreased • Alteration in thinking	Verbally intervene by indicating that the behavior is not acceptable and redirect.
Severe	• Heart rate near or above 100 bpm • Problems processing information • Tunnel vision • Deterioration of complex motor skills • Very limited perceptual field	Set limits with simply stated directions since problems processing information are evident at this stage.
Pain	• Heart rate over 100 bpm • Inability to problem-solve or process information • Becomes irrational and a potential danger to self and others • Develops increased strength-based abilities and gross motor skills (hitting, throwing objects, walking, or running)	GAIN the attention of the team and avoid being alone with the individual while approaching the exit while speaking at the same time. Yell loudly for assistance if this is not possible, call security or 911, and activate the speaker on your phone if able. It may be necessary to consider chemical or physical restraints at this point per institutional protocol if all other efforts have failed.

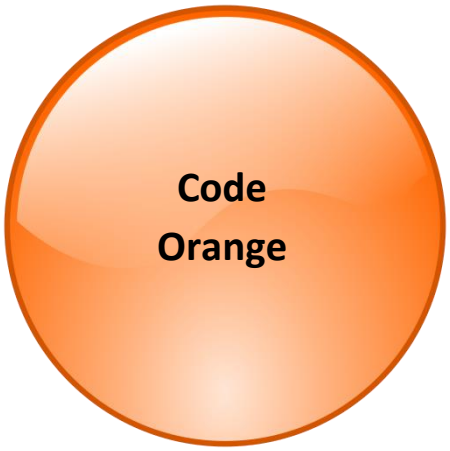
GAINS Mnemonic

Verbal and non-verbal signs and symptoms that indicate potentially escalating and violent behavior

G	**G**estures of anger that include but are not limited to prolonged staring, shaking/clenching a fist, door-slamming, and throwing objects
A	**A**cting in a suspicious, fearful, anxious, or hostile manner
I	**I**ncongruent behavior inconsistent with words as in stating that he/she is “fine” while becoming increasingly agitated and pacing the room
N	**N**oticeable signs and symptoms of stress such as flared nares, jugular vein distention, diaphoresis, increased blood pressure and heart rate
S	**S**ystematically tapping feet, pacing, sighing, shaking knees, clenched jaws, or repeatedly running fingers through the hare or across the forehead

Code Orange Button

(Call for Assistance)



References

Davis, C., Landon, D., & Brothers, K. (2015). Safety alert: Protecting yourself and others from violence. *Nursing, 45*(1), 55-59. doi:10.1097/01.NURSE.0000454955.88149.e4

Department of Veterans Affairs. (2011). *VHA National patient safety improvement handbook (VHA Handbook 1050.01).* Washington, DC: VHA Publications.

Department of Veterans Affairs Veterans Health Administration. (2013). *Mental health handbook* (VHA Handbook 1160.06). Washington, DC: VHA Publications.

Hodgson, M. J., Mohr, D. C., Drummond, D. J., Bell, M., & Van Male, L. (2012). Managing disruptive patients in health care: Necessary solutions to a difficult problem. *American Journal of Industrial Medicine, 55*, 1009-1017. doi:10.1002/ajim.22104

The Joint Commission. (2016). *2016 Hospital national patient safety goals*. Retrieved from http://jointcommission.org

Knox, D. K., & Holloman, G. H. (2012). Use and avoidance of seclusion and restraint: Consensus statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. *Western Journal of Emergency Medicine, 13*(1), 35-40. doi:10.5811/westjem.2011.9.6867

Montalvo, I. (2007). The national database of nursing quality indicators (NDNQI). *OJIN: The Online Journal of Issues in Nursing, 12*(3), Manuscript 2. doi:10.3912/OJIN.Vol12No03Man02