Verbal De-Escalation Strategies in the Acute Care Setting
An Integrative Review of the Evidence

Clinical Question: What is the quantity, quality, and consistency of the evidence for verbal de-escalating best practices to mitigate disruptive, agitated and/or violent behavior for the adult patient/visitors in the acute care setting (Medical-Surgical, Intensive Care Unit [ICU], and emergency department [ED])?

Conclusions: Verbal de-escalation has been defined as a resolution of a potentially violent and/or aggressive situation through the use of verbal and physical expressions of empathy, alliance, and non-confrontational limited setting. This important therapeutic process helps counter the growing issues of patient or visitor aggression. Commonly cited tactics used by collaborative healthcare teams are negotiation, problem solving, limit setting, and verbal feedback (See verbal loop, Page 8). Literature to date states that these techniques are the first line in preventing and managing potentially dangerous behaviors for the safety of all persons and hospital property. These strategies have the potential to decrease the detrimental effect of patient aggression on multiple outcomes, including staff efficiency and moral, sick leave, disruption to quality patient care, and cost of staff injuries. Verbal de-escalation is a learned technique that requires initial and ongoing education for key healthcare providers.

Key Summary of the Evidence: Psychiatric emergencies can occur in any healthcare setting. Nurses can expect to care for patients who are at risk for or are actively experiencing a behavioral health crisis. Nurses should know the situation, the patient, and themselves. The following evidence is offered to guide staff nurses and nursing leaders in this important area of clinical practice:

- Patients can use verbal de-escalation techniques to maintain a therapeutic nurse/patient relationship and manage, maintain, or regain self-control.
- Verbal de-escalation is the first line of intervention (unless patient is actively violent) where one team member coordinates and manages the phases of pre-escalation, verbal de-escalation, and post-de-escalation.
- Current verbal de-escalation guidelines integrate the best available research and expert consensus and include:
  - Project BETA Ten Domains of De-escalation (See Page 6)
  - The National Institute of Clinical Excellence (NICE) Guidelines (See Page 9)
  - Evidence-based de-escalation education consists of ongoing orientation to the physical environment, physical/cognitive/mental status assessment skills, and additional skills in aggression management training.
  - How to manage aggression, de-escalate difficult situations, and learn breakaway techniques for escape using minimal physical force.
  - Evaluation of effective verbal de-escalation training programs involve understanding what works for whom, when, and in what circumstances.

Recommendations: The following recommendations are offered for Chief Nurse Executives and other nursing leaders wishing to implement verbal de-escalation strategies for staff nurses in the emergency department and acute care settings:

- Promote the utilization of common team tactics such as negotiation, problem solving, limit setting, and verbal feedback.
- Incorporate objective scales, frameworks, and models to assess, prevent, and manage patient agitation, as well as mitigate staff behaviors.
- Provide strong leadership support to ensure that nurses are equipped with the necessary knowledge, skills, and attitudes they need to effectively manage violence and aggression.
- Staff should be aware of the warning signs and characteristics of potentially violent patients (See Next Page)
- Implement locally developed action plans, policies, and guidelines that provide clear direction to staff on how to manage violence and call for help in a behavior emergency.
- Expand the physical environment of de-escalation to include hospital security, alarms, security training, building structure, and environmental measures.
- Develop an administrative quality management review process to evaluate verbal de-escalation programs and improve patient/staff outcomes in managing aggressive behavior.
### Table 1

**Patient Characteristics of Potentially Violent People**

| Psychiatric | • Psychiatric issues  
| • Mental illness  
| • Altered perception  
| • Social restlessness  
| • Delusion  
| • Poor collaboration with suggested treatment | • Boredom  
| • Anxiety  
| • Paranoid idea  
| • Hallucination  
| • Agitation  
| • Antisocial | • Preoccupation with violent fantasy  
| • Excitement  
| • Over Hostility or suspiciousness  
| • Explosive or impulsive personality traits of disorder |
| Medical | • Medical illnesses  
| • Organic disease  
| • Adverse drug reaction  
| • Head injury/brain injury | • Hypoxia  
| • Infection  
| • Hypoglycemia  
| • Physical illness | • Delirium  
| • Cerebral irritation  
| • Pain  
| • Confusion |
| Substance Use | • Alcohol and drug intoxication and withdrawal  
| • SubSTANCE misuse | • History of misuse of substances or alcohol |
| Environmental | • Excessive or constant noise  
| • Staff shortage  
| • Lack of understanding of triage times and categories | • Heat  
| • Lack of choice  
| • Inadequate staff training | • Group/peer pressure  
| • Lack of information  
| • Having no right of appeal to decisions made  
| • Perceived negative staff attitudes |
| Social Characteristic | • <30 years of age  
| • Multiple arrests  
| • Dishonorable military discharge  
| • Care giver reporting previous anger or violent  
| • Verbal threat of violence  
| • Loss of parent before age of 8 years | • Male  
| • Previous expression of intent to harm others  
| • Evidence of recent severe stress  
| • Reckless driving | • Patients with problems with authority  
| • Previous history of violent attack  
| • Previous use of weapons  
| • Particularly loss of event or the threat of loss  
| • History of bed wetting  
| • Cruelty of animals |
**Verbal De-Escalation Strategies in the Acute Care Setting**

*An Integrative Review of the Evidence*

**Table 2**

**Warnings Signs - Behaviors of Potentially Violent People**

<table>
<thead>
<tr>
<th>Behaviors</th>
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<tbody>
<tr>
<td>- Tense and angry facial expression</td>
<td>- Prolonged eye contact</td>
</tr>
<tr>
<td>- Increased or prolonged restlessness, body</td>
<td>- Withdrawal</td>
</tr>
<tr>
<td>tension, pacing</td>
<td>- Fear</td>
</tr>
<tr>
<td>- Discontentment</td>
<td>- Irritation</td>
</tr>
<tr>
<td>- Refusal to socialize and/or communicate</td>
<td></td>
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<tr>
<td>- General over-arousal of body systems</td>
<td></td>
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<tr>
<td>- Increased breathing + heart rate</td>
<td></td>
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<tr>
<td>- Muscle twitching</td>
<td></td>
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<tr>
<td>- Dilated pupils</td>
<td></td>
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<tr>
<td>- Increased volume of speech, erratic</td>
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<tr>
<td>movements</td>
<td></td>
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<tr>
<td>- Blocking escape route</td>
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Chin-Hong No, RN, MSN; June Rondinelli, PhD, RN, & Cecelia L. Crawford, DNP, RN; ©Kaiser Permanente SCAL Nursing Research Program, July 2014
Figure 1

**Recommended Seclusion & Restraint Algorithm**


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Verbal De-Escalation Topic Summary

### Verbal De-escalation Goals

**Treatment**
- **Patient**
  - Maintain therapeutic relationship with the nurse
  - Manage, maintain, or regain control of self
  - Avoid coercive interventions
- **Staff**
  - Maintain therapeutic relationship with the patient
  - Manage potentially dangerous behaviors
  - Provide best possible care and management
  - Stabilize the acute crisis rapidly

**Safety**
- **Organization**
  - Ensure the safety of the patient, staff, visitors, and hospital property.

### Verbal De-escalation Outcomes

**Patient**
- Verbal de-escalation allows engagement in a therapeutic nurse-patient relationship, which creates rapport with the nurse.
- Verbal de-escalation has the potential to:
  - Be calmed and maintain or regain self-control without forced medication or restraints.
  - Decrease mistrust/fear of medical personnel and seek help earlier.
  - Reduce violence and avoid agitation, with a decrease in patient injuries.

**Staff**
- Verbal de-escalation has the potential to improve staff injuries rates and increase staff self-esteem and job satisfaction.
- Staff use of verbal de-escalation allows them to engage in a therapeutic relationship and create rapport to gain the patient’s trust.

**Organization**
- Verbal de-escalation can be effective in a relatively brief period and has the potential to:
  - Decrease hospital admissions and prolonged lengths of stay, with easier and more rapid disposition to other facilities.
  - Improve factors such as staff sick leave, cost of staff injuries, staff morale, and disruption to quality patient care.

### Strategies of De-Escalating Violent behavior

**Pre-Escalation:** A interactive strategy that can positively influence the outcome of potentially dangerous situations.
- **Characteristics of Potentially Violent People** (See Table 1, Page 9)
- **Patient Behaviors – Warning Signs** (see Table 2, Page 10)
- **Pre-escalation strategies for staff**
  - **Setting the Stage**
    - Remove dangerous objects from own person
    - Separate patient from group
    - Be aware of exits
    - Avoid vulnerable positions (do not turn back on the patient)
  - **Patient Engagement**
    - Use shared problem solving
    - Use distraction and redirection
    - Outline consequences of behavior
    - Avoid provocation, challenges, and promises whenever possible
    - Enforce limits
Verbal De-Escalation Strategies in the Acute Care Setting
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- **Verbal De-Escalation**\(^2;3;8;9;12\)
  - **Verbal De-Escalation**: A gradual resolution of a potentially violent and/or aggressive situation via verbal/physical expression of empathy, alliance and non-confrontational limit setting; *the encounter is based on respect combined with an early action plan*\(^3;8;12\)
    - Requires flexibility and creativity\(^9\)
    - Based on individual needs and characteristics of each patient displaying aggression\(^9\)
    - Involves the techniques of defusing, negotiation, and conflict resolution\(^3;9;12\)
  - Although the approach is team-based, one staff member should take control of the situation\(^8;10\)
  - Use specific protocols, guidelines, policies, and procedures to structure a safe de-escalation situation\(^3;4;8;10\)
    (See Protocol, Guidelines, Policies, and Procedures section, Page 2)
  - Nurses have other patients to care for\(^2\)
    - Continue to provide safe environment for all staff/patient\(^2\)
    - Remain aware of how long the de-escalation process is taking\(^2\)

- **Project BETA (Best Practices in Evaluation & Treatment of Agitation): Ten Domains of De-escalation**\(^10\)
  - **1. Respect Personal Space (Patient and Staff)**\(^10\)
    - Maintain at least two arm’s lengths of distance\(^10\)
      - Space needed to move out of the way if patient were to kick or otherwise strike out\(^10\)
  - **2. Do Not Be Provocative (Avoid Iatrogenic Escalation)**\(^10\)
    - Demonstrate body language that staff will not cause patient harm the patient, wants to listen, wants everyone to be safe\(^10\)
  - **3. Establish Verbal Contact (Only 1 Person Verbally Interacts)**\(^10\)
    - Introduce self to patient\(^10\)
    - Provide orientation and reassurance\(^10\)
  - **4. Be Concise and Keep It Simple (Repetition is Essential)**\(^10\)
    - Persistently repeat message to the patient until it is heard\(^10\)
  - **5. Identify Wants and Feelings**\(^10\)
    - Use trivial things the patient says, his body language, or even past encounters to respond empathically and express a desire to help patient get what he wants\(^10\)
  - **6. Listen Closely to What the Patient Is Saying (Use Active Listening)**\(^10\)
    - Miller’s Law: “To understand what another person is saying, you must assume that it is true and try to imagine what it could be of.”\(^10\)
  - **7. Agree or Agree to Disagree**\(^10\)
    - Agree with the truth, principles, and odd of patient’s position\(^10\)
    - If there is no way to honestly agree with the patient, agree to disagree\(^10\)
  - **8. Lay Down the Law and Set Clear Limits (Establish Basic Working Conditions)**\(^10\)
    - Treat with respect and dignity\(^10\)
    - Limit setting must be reasonable and done in a respectful manner\(^10\)
  - **9. Offer Choices and Optimism**\(^10\)
    - Provide hope: Offering choice can be a powerful tool for the patient who has nothing left but fight or flight\(^10\)
  - **10. Broach the Subject (Debrief Patient and Staff)**\(^10\)
    - Restore a therapeutic relationship to alleviate traumatic nature of coercive intervention and decrease risk of additional violence\(^10\)

- **Post De-Escalation**\(^3;10;12\)
  - Debrief staff and patient\(^3;10;12\)
    - Restore the therapeutic nurse/patient relationship\(^3;10;12\)
    - Alleviate traumatic nature of the de-escalation intervention\(^3;10;12\)
    - Decrease risk of additional violence\(^3;10;12\)
    - Maintain an environment where staff learn from debriefing on the recent situation and reflect on their management\(^3;10;12\)
Verbal De-Escalation Strategies in the Acute Care Setting
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- **Assessment**
  - **Situation**: Proficient at reading a dangerous situation and assessing the potential impact of the situation. Ability to notice what constituted the beginning of incident. Know the situation. Consider patient specific dimensions of dignity, gender-sensitivity, cultural-sensitivity, and social/spiritual expression.
  - **Patient**: Know the patient. Identify psychiatric problems early during assessment and medication reconciliation to determine if aggression is due to behavior or medical cause.
  - **Staff**: Assessing what level of staff support is necessary for safe de-escalation. Clinician should self-monitor and feel safe by assessing their temperament when approaching the patient. Staff should know themselves and screen whether they are effective de-escalators.
    - Open, honest, supportive
    - Self-aware, coherent, non-judgmental
    - Confident, without appearing arrogant
  - **Environment**: Physical space should be sufficient and designed for safety. Remove/secure objects that can be used as weapons. Manage others in the physical environment by: Removing other patients from the area. Enlisting help of colleagues. Creating space. Explain to person and others in immediate vicinity what they intend to do. Give clear, brief, assertive instructions. Move towards a safe place and avoid trapped in a corner. Macro level of management includes hospital security, alarms, security training, building structure, and environmental measures.

- **Communication Strategies**
  - Verbal Communication Principles:
    - Use a calm, warm, clear tone of voice; make short, brief, specific statements; use open ended sentences. Express feeling and concerns.
    - Avoid use of jargon and punitive or threatening language.
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- **Verbal Loop:**
  1. Clinician listens to patient
  2. Finds a way to respond that agrees with or validates the patient's position
  3. States what the patient wants the patients to do (e.g., accept medication, sit down etc.)
  4. Continues verbal loop as needed

- **Nonverbal Communication Principles:**
  - Keep an open body posture at the same height as the patient
  - Maintain a comfortable proximity of at least one meter
  - Keep a congruent facial expression
  - Be aware of body language in terms of intention movements, eye contact, touch, and facial cues

- **Negotiation, Problem Solving, and Limit Setting**
  - Create a win-win situation
    - Create a sense of empowerment in the client by shifting the focus from confrontation to a discussion with the use of reasoning
  - Offer Alternatives to Aggression
    - Negotiate realistic options
    - Offer alternative activities, teach coping mechanisms, or suggest new responses to frustrating situations
  - Limit Setting
    - Involves knowing when to exert control and implement constraints on patients’ behavior
    - Control and contain aggression while also maintaining a therapeutic alliance

- **Collaborative Team Work**
  - An adequate number of trained staff must be available
  - De-escalation team should consist of 4 to 6 team members
    - Trained nurses, clinicians, and technicians
    - Police and security officers (if available)
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Education/Staffing/Training/Staff Skills

- **Initial Training**
  - It is essential that clinical managers have high quality evidence regarding both the effectiveness of training programs, and what works for whom, when, and in what circumstances.
  - **Knowledge and Skills**
    - Physical assessment
      - Medical assessment is essential to rule out life-threatening causes of agitation, but patient might not be cooperative with evaluation.
    - Cognitive assessment
      - Recognize cognitive impairment—delirium, psychosis, intoxication, or intellectual disability.
      - Learn to balance how to evaluate and manage the patient simultaneously.
    - Mental status assessment
      - Facilitate quick and accurate identification of the cause of aggression.
  - **Violence and Aggression Management Training**
    - Providers should be well educated and competent to manage aggression, de-escalate difficult situations, and use breakaway techniques to escape by using minimal physical force.
    - Teaches the ability to maintain a de-escalating demeanor in order to control escalating situations.
    - Includes an awareness of racial, cultural, religious/spiritual needs, and gender differences, along with any other special concerns.

- **Annual/Ongoing training**
  - The American Psychiatric Association Task Force on Psychiatric Emergency Services, CMS guidelines, and other clinical experts recommend training on an annual basis and should include:
    - Prediction of escalation.
    - Verbal de-escalation techniques with negotiation skills.
    - Prevention and management of aggressive behavior.
    - Ongoing one-to-one skills and support.

Protocols, Guidelines, Policy, and Procedures

- Action plans should be developed at a local level that details how to call for help in an emergency.
- Policies or guidelines can give staff clear direction on how to manage violence in the healthcare area.
  - **Note:** Not all of guidelines can be followed in every patient situation.
  - All providers should have a policy for training employees and staff-in-training in short-term management of disturbed/violent patient behavior.
  - The policy should specify who will receive what level of training, how often they will be trained, and outline the techniques in which they will be trained.
  - Project BETA (Best Practices in Evaluation and Treatment of Agitation) is a patient-based guideline sourced from the best available research combined with expert consensus.
    - See Project BETA: Ten domains of de-escalation guidelines (See Page 4).

- **The National Institute of Clinical Excellence (NICE) Guidelines**
  - **Interpersonal Skills:** Authentic engagement of staff who remains sincerely connected with the patient.
    - Empathy.
    - Warm.
    - Genuineness.
    - Reciprocity.
    - Respect.
    - Mutuality.
  - **Communication Skills**
    - Speak in a calm and controlled manner.

  - **Ability to Assess the Initial Situation**
    - Proficient at reading a dangerous situation and assessing its potential impact.
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- Ability to notice what constituted the beginning of incident\textsuperscript{8,12}
- **Patient/Nurse Collaboration**\textsuperscript{2,5,8-10,12}
  - Offer patient suggestions and choices in a respectful manner that embrace reciprocity and encourage a therapeutic engagement\textsuperscript{2,5,8-10,12}

### Tools: Scales, Frameworks, and Models\textsuperscript{2,5,9,10}

- Use objective scales, tools, frameworks, and models to assess, prevent, and manage patient agitation, as well as mitigate staff behaviors that might result in missing the early signs of agitation\textsuperscript{1,10,12}
- There are relatively few tools or user friendly risk-stratification surveys\textsuperscript{13}
- **Behavioural Activity Rating Scale (BARS)**\textsuperscript{10} Note: Any score other than a 4 should trigger an evaluation and establish the urgency
  - 1= Difficult or unable to rouse
  - 2= Asleep but responds normally to verbal or physical contact
  - 3= Drowsy, appears sedated
  - 4= Quiet and awake (normal level of activity)
  - 5= Signs of overt (physical or verbal) activity, calms down with instructions
  - 6= Extremely or continuously active, not requiring restraint
  - 7= Violent, requires restraint
- **STAMPEDAR**: A framework that offers nurses working in all hospital areas a risk assessment tool for predicting and managing episodes of workplace violence\textsuperscript{1}
  - Describes cues that nurses use to predict risk of workplace violence to include not only perpetrator factors, but also patient and organizational characteristics\textsuperscript{1}
  - Has the potential to decrease the number of violence patient episodes, increase a sense of staff control, and improve staff satisfaction\textsuperscript{1}
  - **STAMPEDAR Components**\textsuperscript{1}
    - Staring (or no eye contact)
    - Tone (Quality/volume of voice, aggressive tone, demanding, name calling, swearing)
    - Anxiety
    - Mumbling and Muttering
    - Pacing (Refusing to stay in room or bed)
    - Emotions (Unhappy, frightened, frustrated, dissatisfied with care)
    - Disease process (Confusion, drugs/alcohol intoxication, organic disorders)
    - Assertive/non-assertive (Disrespectful, confrontational, over assertive, passive)
    - Resources (Long wait times, staff inexperience, staff knowledge and skill level, inappropriate communication styles)
- **Robertson et al Model of Escalation and De-escalation**\textsuperscript{12}
  - **Triggering Phase**: Dominant emotion is anxiety- agitated or avoidant behavior\textsuperscript{12}
    - Transition toward a negative perception of current situation; marked by anger\textsuperscript{12}
    - **De-escalation technique**:\textsuperscript{12}
      - Maintain communication and minimize factors\textsuperscript{12}
      - Focus on attending to and communicating with the patient using active listening skills such as open questions, paraphrasing, and reflection, as well as interpersonal skills of warm, empathy, and genuineness\textsuperscript{12}
  - **Crisis State Phase**: Anger becomes focused on specific people; others’ behaviors likely to be interpreted as threatening\textsuperscript{12}
    - Destructive behavior: Impulse control reduced; physical aggression most likely\textsuperscript{12}
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- **De-escalation technique**
  - Risk management:
    - Move bystanders
    - Contain threatening behavior
    - Outline possible consequences and outcomes of the client’s behavior
    - Use conditional limit-setting
    - Distraction/diversion
  - Descent Phase: Arousal levels begin to reduce, although perception remains heightened
    - Immediate risk to others decreases, although anger is still dominant emotion
    - Resolution: Depression, physical exhaustion, disorientation, and contrition
  - **De-escalation technique**: Focus on imposing appropriate sanctions, as well as continuing to explore the underlying triggering issues

**Nursing Implications**

- Nurses must aim to maintain self-awareness throughout all interactions
  - Focus on developing effective therapeutic relationships and use de-escalating techniques in order to reduce the frequency of escalating incidents
- A model of aggressive behavior and a theory of interpersonal behavior can be used by nursing staff who are attempting to understand, prevent, and manage aggression
- Nurses can develop the ability to effectively forecast volatile events and use de-escalating strategies to prevent, contain, and manage patients with violent behaviors
  - Greater sense of control
  - Increased job satisfaction
- Know the situation, patient, and yourself

**Future Research**

- Further empirically based research studies are needed for the following topics:
  - A richer understanding of limit-setting and de-escalation concepts and their use in practice
  - Effectiveness of training in de-escalation techniques
  - How verbal de-escalation techniques may differ for age groups and specific psychopathologies
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References


Evidence Search Strategies: A comprehensive search strategy was used to identify published English written evidence between January 2008 to February 2014. The initial search was conducted via PubMed, CINAHL, Science Direct, PsycNET, and Cochrane Library using key words(s) and/or controlled vocabulary of “emergency department,” “adults,” and “de-escala*”, either alone, mixed, or in combination. A second search was conducted using the same electronic databases for another set of key words(s) and/or controlled vocabulary terms of “emergency department,” “workplace violence,” “aggressive behavior,” and “de-escala*”. To ensure that the search results were comprehensive and included all acute care hospital areas, a third search was conducted using the same electronic databases as well as Google Scholar and Yahoo for the key search term of “verbal de-escalation.”

5526 total references were identified. Relevant articles were then retrieved and 22 were initially selected for inclusion. The criteria for inclusion for more detailed analysis were a) adult patients, b) all hospital settings and/or the acute care setting, c) de-escalation best practices, interventions, and/or techniques, d) disruptive behavior, e) violent behavior, and f) nursing only. Six duplicate articles were excluded. Twelve additional articles were excluded as they did not pertain to the clinical question (nurses’ attitudes, program evaluation, and emergency department (ED) security program). Ten relevant articles remained and 3 contextual articles were added. Therefore, a total of 13 articles were included in the final evidence review. The evidence consisted of 1 meta-synthesis of qualitative studies, 3 descriptive studies, 3 literature review, 1 evidence based consensus statement with guideline, 4 expert consensus statements, and 1 expert opinion. There is limited evidence on verbal de-escalation in ED, and even less evidence for the acute care setting. Therefore, this review covers both areas based on best available practices.
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Search Terms: Emergency Department, adults, de-escal*, workplace violence, aggressive behavior, and verbal de-escalation (alone, mixed, or in combination)

Limits: English language articles, 2008-2014

Exclusion Criteria: Pediatric population, best practices/interventions/techniques other than de-escalation, physical/environmental intervention (i.e. restraints, seclusion), pharmacological therapy, healthcare professionals other than nursing

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses; 4/2012
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**Electronic Database Search Methodology**

**Date(s):** February 2014  
**Evidence search topic/clinical question:** What are the quantity, quality, and consistency of the evidence for de-escalating best practices to mitigate disruptive and/or violent behavior for the adult patient in the acute care setting (Med-surg, ICU, and emergency department)?  
**Inclusion Criteria:** Adult patients, all hospital setting, de-escalation best practices/interventions/techniques, disruptive behavior by patients, violent patient behavior, nursing only  
**Exclusion Criteria:** Pediatric population, best practices/interventions/techniques other than de-escalation, physical/environmental interventions (i.e. restraints, seclusion), pharmacological therapy, healthcare professionals other than nursing

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Years: 2008-2014 | Emergency department AND workplace violence AND aggressive behavior AND de-escala* | 1 | 0 | 0 | 0 | 0 | 0 |

Adapted from Toolkit for Promoting Evidence-Based Practice Form 4/Appendix G© Research, Quality and Outcomes Management, Marita G. Titler, PhD, RN, FAAN, Director, Research, Quality and Outcomes Management

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<table>
<thead>
<tr>
<th>Database</th>
<th>Key Word(s) and/or Controlled Vocabulary Terms</th>
<th>Total References Identified (hits)</th>
<th>No. of Relevant References</th>
<th>No. of Total Duplicate Articles</th>
<th>No. of Articles Selected for Review</th>
<th>No. of Articles Excluded</th>
<th>Final Total Relevant References</th>
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<td>Name: Google Scholar Years: Open</td>
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</tbody>
</table>

*Reference/Contextual Links


*Additional articles/information found in references lists and/or article review

Total Articles Included in Literature Review: Database (10) + Contextual Links (3) = 13

#Additional articles/information found in references lists and/or article review

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### CCIRES Evidence Leveling System (ELS)

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
<th>RELEVANT ARTICLES</th>
<th>ARTICLE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Meta-analysis of multiple large sample or small sample* randomized controlled studies, or meta-synthesis of qualitative studies with results that consistently support a specific action, intervention, or treatment</td>
<td>Price &amp; Baker, 2012</td>
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</tr>
<tr>
<td>B</td>
<td>Well-designed controlled studies, both randomized and nonrandomized, prospective or retrospective studies, and integrative reviews with results that consistently support a specific action, intervention, or treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Qualitative studies, descriptive or correlational studies, integrative reviews, systematic reviews, or randomized controlled trials with inconsistent results</td>
<td>Chapman et al., 2009, Cowin et al., 2003, Kelley &amp; Hyannis, 2014</td>
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</tr>
<tr>
<td>D</td>
<td>Peer-reviewed professional organizational standards, with clinical studies to support recommendations</td>
<td>NICE, 2005</td>
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</tr>
<tr>
<td>MA</td>
<td>Manufacturer’s recommendation; Anecdotes</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

### CCIRES Strength of Recommendation Taxonomy (SORT) for Grading the Evidence

- Evidence graded as “Good” (1) = 0 articles
- Evidence graded as “Fair” (2) = 3 articles
- Evidence graded as Insufficient (3) = 10 articles

**Summary of the Strength of the Body of Evidence**

3 = Insufficient

The summary of the body of the evidence based on consensus, usual practice, opinion, disease-oriented evidence and demonstrates good quality patient-oriented evidence, case series, and case studies

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