

Appendix: Behavioural Management of Agitation following Brain Injury

If Agitation is present:

1. Refer to Management of Post Traumatic Agitation Following Brain Injury Algorithm
2. Complete the Agitated Behaviour Scale (ABS). If score is > 21, initiate ABS q hourly for an 8 hour shift. When the total shift score is <21 for 3 times (24 hours), discontinue ABS.
3. Rule out potential medical causes/ delirium (see Agitation Algorithm)
4. Remember: **behavioural management of the agitated patient with brain injury is a highly individualized approach.**

The behaviour can be difficult to manage and frustrating for staff, **but patients with brain injury become agitated as part of the recovery process and cannot control their behaviour.** They are not being deliberately manipulative, mean or rude. The Rancho Los Amigos Scale describes the stages of recovery from brain injury. Stages III-V include restlessness, confusion/ agitation and sometimes aggression.

	RESTLESSNESS	CONFUSION	AGGRESSION
Behaviour	You may see: <ul style="list-style-type: none"> - Heightened activity - Unable to process information - NON-purposeful body movements (continuous rubbing, scratching, rocking) 	<ul style="list-style-type: none"> - Periodic confusion - Inappropriate but goal-directed behaviour - Attempts to remove lines/ tubes - Trying to get out of bed - Wandering 	<ul style="list-style-type: none"> - Aggression: verbal or physical; <u>with potential to harm self or others</u>
Intervention	<ul style="list-style-type: none"> - Monitor frequently - Assess and document ABS q8h - Low bed/ mattress on floor for safety - Special padding or positioning - Move closer to nursing station if possible 	Interventions for restlessness, plus: <ul style="list-style-type: none"> - Intermittent physical restraints may be required. Complete appropriate documentation and close monitoring - Use environmental restraints (Wanderguard, ½ door, etc.) 	Interventions for restlessness and confusion, plus: <ul style="list-style-type: none"> - Refer to specific interventions for alternatives for aggression
Goal = Safety	Provide a protective environment with freedom of movement	Ensure patient safety and continuity of necessary medical treatment	Provide a safe environment without provoking further aggression; ensure continuity of necessary medical treatment
Cautions	At this stage movements are non-purposeful and restraints should not be needed. Refer to specific interventions for preventing removal of tubes, positioning & fall prevention.	Physical restraints or presence of 1:1 may cause or increase agitation or aggressive behaviours. There is potential injury from improperly used devices.	Presence of 1:1 may increase agitation or aggressive behaviour. Medication administration should be individualized in consultation with MD/NP to ensure consistency.

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<p>Preventing Removal of Tubes:</p> <ul style="list-style-type: none"> - Assess medical necessity of lines/ tubes and advocate for removal (in conjunction with patient/ family wishes). - Provide education regarding treatment benefits and restraint risks- may need to repeat many times. 	<p>Interventions:</p> <ul style="list-style-type: none"> - Cover and disguise tubes with sleeves, kling, pants etc. - Convert IVs to saline locks if possible - Use elbow splints (to keep arms straight) - Try toileting schedule - Provide simple explanations and guided exploration of the tubes - Try neuromitts (not secured)
<p>Alternatives for Wandering/ Agitation:</p> <ul style="list-style-type: none"> - Assess patterns of behaviours, the precipitating factors, timing, duration, frequency, etc. - Assess physical needs (pain, hunger, thirst, fatigue, etc.) as well as emotional, social and exercise needs. 	<p>Interventions:</p> <ul style="list-style-type: none"> - Meet physical, exercise, emotional and social needs in a safe environment - Respond to the patient's feelings (ie. "you must be lonely", instead of "you can't go home") - Post photos, signs, name or familiar objects on door - Post picture or toilet on washroom door - Provide familiar objects at bedside (ie. bedspread) - Adjust level of stimulation to patient needs - Place patient's chair at nursing station - Distract patient with activity - Arrange family/ volunteer visits at peak times - Redirect in a positive manner (ie. "come with me", instead of "don't go out/there")
<p>Alternatives for Positioning:</p> <ul style="list-style-type: none"> - Assess nature of problem (eg. sliding/leaning/falling forward/knees swept to one side); as well as length of time before positioning problems occur. Consider fatigue, pain, time of day or other precipitating factors. 	<p>Interventions:</p> <ul style="list-style-type: none"> - Check with OT/PT regarding the best chair or mobility aid available - Position hips, knees, and ankles as close to 90 degrees as possible (keep in mind concurrent injuries that may prevent this); neutral positioning - Ensure buttocks and thighs are fully supported on the seat and weight is not on one small area alone - Ensure feet are flat on the footrests or floor to prevent sliding, shifting or leaning - Consider tilt position for rest periods - Monitor skin integrity - Link with PT/OT for options re: bed positioning, pillows, wedges etc.
<p>Fall Prevention Alternatives:</p> <ul style="list-style-type: none"> - Assess for risk factors of falls (eg. altered mental status, impaired mobility/balance/gait, weakness, medications, sensory imbalance, bowel or bladder urgency) 	<p>Interventions:</p> <ul style="list-style-type: none"> - Individualize care based on patient risk factors - Monitor mental status - Refer to OT/PT for gait aids/ positioning - Toileting schedule - Consider most appropriate side rails (one, two, partial; bed against wall) - Put mattress on floor or use mat beside bed - Bed exit alarm - Room close to nursing station - Consider observer/ family supervision - Patient/family education re: falls risk management - Review medications - Least restraint if other methods ineffective
<p>Alternatives for Aggression:</p> <ul style="list-style-type: none"> - Assess often for early signs of escalating behaviour (ie. verbal abuse, conflict with others, pacing, agitation, anger, distress) - Assess underlying causes (ie. physical illness, pain, medications, fear, control issues, needs being ignored, information needs, etc) 	<p>Interventions:</p> <ul style="list-style-type: none"> - Modify routine as needed - Don't take it personally; don't argue with the patient; don't threaten - Provide opportunity for patient to work out feelings in a non-threatening manner - Offer choices to help patient regain control - Consider quiet time in a room; 1:1 talk with staff, reduce stimuli, play soft music; try distractions such as a game or activity; offer food/ beverage/ meds as appropriate and remain with patient until they settle - Kindly but firmly explain expected behaviour and identify your intent to help and explain your actions - Reduce environmental stimuli, close the door; you may need to walk away

Taken from Behavioural Management of Agitation following TBI, Developed by Sunnybrook Health Sciences Centre

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Environmental Changes (Developed by St. Michael's Hospital)

- Provide a quiet, calm environment.
- Establish a reality orientation centre in the room. (i.e. the white board)
- Keep noise and activity to a minimum to reduce stimuli that are competing for attention. Try not to have more than 1 person speaking at once.
- If the behaviour escalates, shut the curtains and doors. Have extra people leave.
- Try to keep some of the same routines each day to decrease confusion. Make a care plan.
- Limit the number of visitors to 1 or 2 at a time.
- Dim the lights. (But try to maintain a day/night routine where there are rest periods, but still enable the patient to sleep at night)
- Shut off the television to reduce stimuli.
- If the patient is agitated, he/she may need to be moved to a private room.

Management of the Confused Patient (Developed by St. Michael's Hospital)

Confusion results from the inability of patients to recall minute-to-minute, hour-to-hour, or day-to-day events in their life. As a result, they are unable to understand their current situation in light of what has or will occur. Associated problems in diminished attention, new learning and orientation are prevalent. The primary approach is to increase the external structure for the individual, particularly in regards to place, time and activities.

- Every patient should have a calendar in their room, a schedule of daily activities posted in the room and on their person (i.e. on the arm of a wheelchair, or a copy for their memory book or pocket) as well as a list of ADL steps posted in their room (can be done in conjunction with OT).
- At the beginning of each shift, review the nurse's name, day, date, room and hospital. Utilize calendar's, clocks, name tags, white boards and signage to reinforce information.
- Maximize consistency within daily routine. Establish a plan of care and communicate that from shift to shift.
- Before each intervention/assessment explain what is expected, at the patient's level of understanding, to increase awareness.
- At the beginning of shift and the end of each interaction, use the patient's schedule to elicit from him or her the next activity in which he/she will engage.

Management of the Impulsive Patient (Developed by St. Michael's Hospital)

Impulsivity is generally a tendency to act without thinking.

- Review the steps before allowing a patient to start. (i.e. with a transfer)
- The patient verbally rehearses out loud the steps needed to complete a task. (If able)

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Management of the Aggressive Patient (Developed by St. Michael's Hospital)

- Demonstrate calm and controlled behaviour; your voice should be soft in volume and low in tone.
- Never attempt to deal with a physically aggressive person alone. Extra members who assist should respond in a quick and calm manner with one person taking charge.
- When approaching a patient, do not confront him/her face to face; approach from the side. Respect personal space. Keep your arms and hands open and below the waist. Avoid cornering the patient and avoid being cornered.
- Talk with the patient about any topic; however, vary content of the talk in order to hold their attention. Do not ask them why they are upset as this may agitate them further.
- Do not make promises that cannot reasonably be kept.
- Assist/ help deal with fears.
- Reinforce positive aspects of self (previous coping).
- Explain what is being done and offer reassurance honestly.
- Encourage venting of feelings rather than acting them out.
- Consistently limit setting for inappropriate behaviour- provide external controls- quiet room; remove from the environment.
- If verbal aggression, let the patient vent anger and expend energy through physical outlets with staff supports.
- Be consistent.
- Avoid power struggles.
- After acting out, re-establish communication for therapeutic rapport.
- Acknowledge the patient's distress and establish your role and intent to be an ally. Never minimize the seriousness of the situation by joking or making light of the events.
- Preface communication with the person's name; hearing one's name is an attention getter. Point out specific events in the environment to focus the patient's attention.
- Give directions for behaviour. Don't expect an emotionally charged person to make complex decisions and adaptive responses. Use specific statements to tell them what to do.
- Avoid arguing or defending. These increase emotional levels and escalate the situation.
- Use a softer than normal tone to de-escalate the situation.
- Avoid threatening body language.
- Encourage thought. Ask "how" or "when" to get the details of his anger.

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Management of the Agitated Patient (Developed by St. Michael's Hospital)

- Treatment sessions should be flexible and the treatment environment should minimize extraneous stimulation.
- Be aware of built up tension, stopping the external stimuli before agitation becomes combative.
- Redirect the patient's attention to less stimulating or frustrating activities until agitation is reduced and a more demanding task can be resumed.
- Do not attempt to discuss agitation logically or elicit guilt for the behaviour.
- Provide encouragement and emotional support to decrease their feelings of insecurity and discomfort and to enhance cooperation.
- Do not leave the patient unsupervised during agitation.
- Maintain consistency in personnel who interact with patient to promote familiarity.
- Permit moving about or verbalization during periods of increased agitation while maintaining safety.
- Maintain your own calm and controlled behaviour; Your voice should be soft in volume and low in tone.
- Observe which interventions calm the patient and incorporate these interventions into the plan of care. i.e. if music calms the patient, utilize this when the patient is agitated.
- Redirect the patient's attention away from the source of agitation.
- Avoid sudden changes and surprises.
- If attempts to change the behaviour fail, leave the room for a cooling off period provided the patient is adequately protected from injury.
- Increase the patient's physical activity with activities such as walking the unit. This may help divert energy.
- If the patient was agitated, at a time when the patient is calm, talk to him/her about the inappropriate behaviour and remind him behaviour can be controlled (if the patient is at an appropriate cognitive recovery level to understand). The patient can be taught to recognize the loss of control and how to intervene with measures such as walking, turning on quiet music or going to a quiet area.
- Praise all efforts at self-control.
- If possible, remove IVs, NGs, foleys. Protectors or binders should be considered when clinically feasible.
- 50% of brain injury patients describe difficulty sleeping. Careful monitoring of sleep cycles and quality of sleep is necessary. Chart hours of sleep. Try to limit caffeine intake and minimize naps during day.
- Refer to Agitation Algorithm.

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Communication/ Teaching for Family and Friends (Developed by St. Michael's Hospital)

- Give short, simple bits of information, short instructions, and short questions. Use repetition if necessary.
- Speak to your loved one as one adult to another.
- Keep the pace slow.
- Be calm and speak slowly.
- Try to tell your loved one information rather than asking a lot of questions.
- Repeat instructions several times.
- Maintain eye contact and use nonverbal signals; point, touch, or hand them something. Demonstrate what you want done.
- Reinforce orientation information. If you leave the room and return, start again.
- You don't need to give a lot of details about the injury, but it is usually more reassuring to know what happened than imagine something worse.
- Watch for signs that your loved one has misinterpreted an event or statement.
- Keep some distance between you. Avoid moving towards him/her suddenly.
- Don't take it personally if he/she swears at you.
- Give verbal or visual feedback about performance.
- Use a calendar to assist comprehension. Use concrete objects to help communicate information.
- Encourage choices between 2 alternatives, so that initiative and independence are encouraged.
- Avoid 3 way conversations, this may be too overwhelming.
- Bring in pictures and familiar objects, music etc.
- It is important that the person is surrounded by familiar people so visit when you are able. Ensure there is only 1-2 visitors at a time. Allow the patient to have adequate rest periods. Most importantly- you need to take care of yourself too!