SAFETY MANAGEMENT PROCESSES TO PROMOTE EFFECTIVE INTERVENTION WITH AGGRESSIVE AND HOSTILE BEHAVIORS

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PREMISE

Aggressive and violent behaviors pose significant safety risks to our consumers, their families, crisis workers and other first responders. It is essential that crisis teams develop best-practice strategies to effectively intervene when these tensions arise. Crisis providers should have well-established internal processes and effective partnerships. The implementation of a best-practice core strategies model has yielded significant positive results with the inpatient psychiatric population at Sharon Regional. This presentation will discuss what has been done to achieve these outcomes and explore how these strategies can be applied within the crisis intervention setting.

OBJECTIVES

Identify safety risks inherent with aggressive and violent behaviors

Identify the six core strategies to promote effective intervention of aggression and violent behaviors and the results of these efforts.

Explore the use of de-escalation strategies within a crisis intervention framework.

SECTION 1

Safety and the Use of Force

RESPONSE TO AGGRESSION: USE OF FORCE

Behavioral emergencies may result in the use of force. Any use of force has the potential to cause injury.

- 4-point restraint
- Locked Door Seclusion
- Physical Holding
- Handcuffs

"IS IT OK IF I TOTALLY TRASH YOUR OFFICE?"
-A PERSPECTIVE ON THE USE OF FORCE

ELLYN SAKS, USC PROFESSOR OF LAW AND PSYCHOLOGY

Audio/Video

A View of Mental illness – From the Inside. Elyn Saks. June 2016. Recorded at TedGlobal, Edinburgh Scotland

WHY AVOID THE USE OF FORCE?

- Injury /Death
- Trauma Response
- Non-therapeutic
- Misused as punishment
- Contraindications

RISK FACTORS TO CONSIDER AND COMMUNICATE BEFORE USING FORCE

- Pregnancy
- Asthma (40% of S/R death due to asphyxiation)
- Fractures
- History of surgery, injuries
- Seizure disorders
- History of physical, emotional or sexual abuse
- Communication deficits, (hearing, blindness, speech, language, etc.)
- Cognitive impairment/ Intellectual Disability

REDUCING THE USE OF FORCE

- Avoiding use and Limiting duration are the two primary means of reducing force.
- Many situations can be resolved through skilled de-escalation.
- When de-escalation fails and force is used as a last resort, the duration and intensity of force should be limited.

SECTION 2

Framework For Organizational Change

SIX CORE STRATEGIES FOR REDUCING RESTRAINT AND SECLUSION

Developed by the National Association of State Mental Health Program Directors (NASMHPD, 2016)

1. **Leadership toward Organizational Change**
2. **Use of Data to Inform Practice**
3. **Workforce Development**
4. **Use of S/R Prevention Tools**
5. **Use of Consumer roles in Inpatient Settings**
6. **Debriefing Techniques**

SIX CORE STRATEGIES: 1 LEADERSHIP

Leadership and Organizational Change

Escalate significant patient or treatment related events in a manner which promotes risk assessment, procedural review and planning to promote safe, effective outcomes

Executive and Midlevel leaders must be actively involved

Set criteria for review process – for example:

- ✓After any injury
- ✓After 3 or more code events called on a single patient in one day or 5 or more code events on a single patient over the course of the admission.
- ✓ Patient has engaged in significant deliberate/ intentional damage to property.
- ✓Overly aggressive behavior that results in concerns about unit safety and resources to handle the situation.

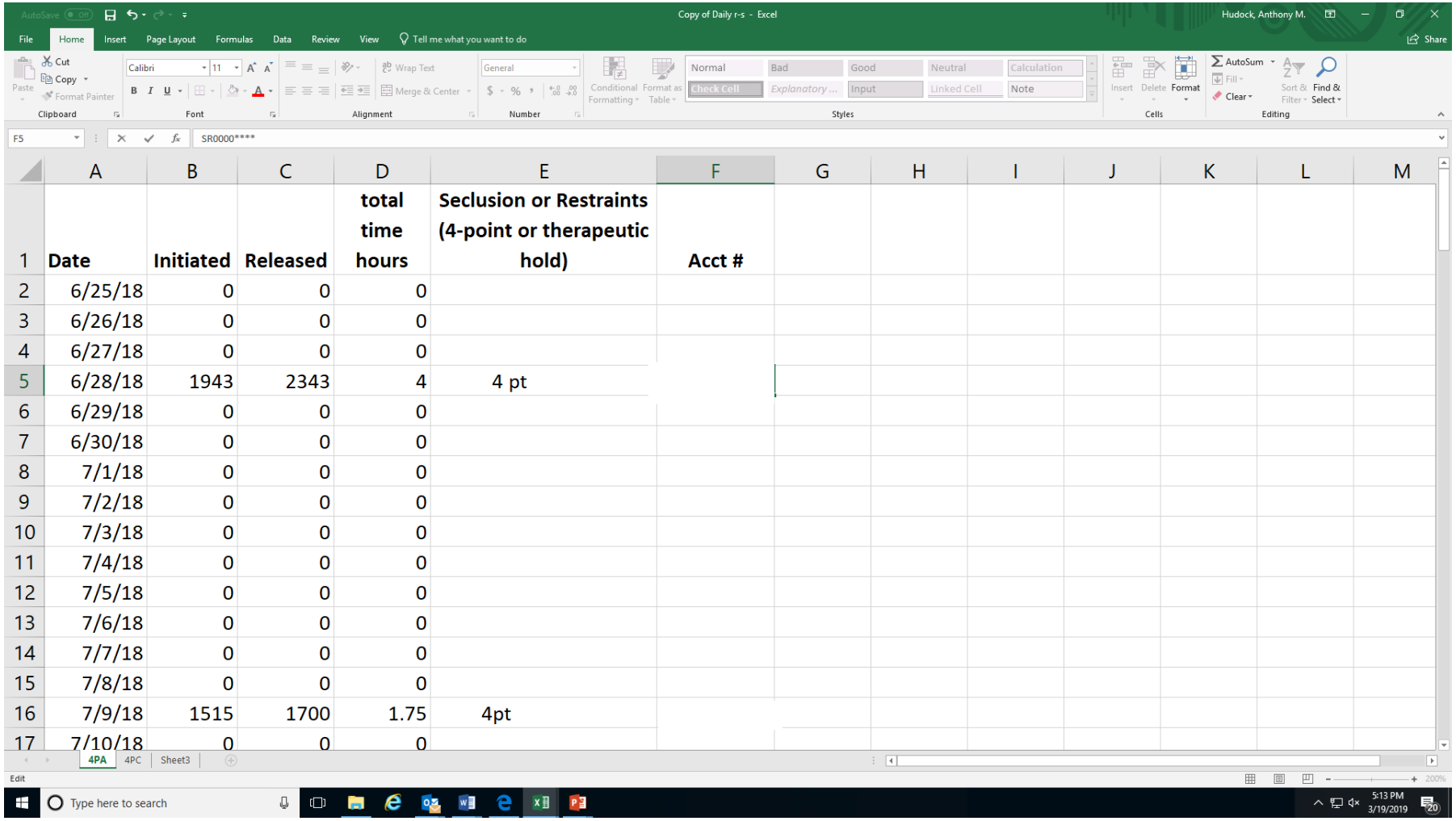
SIX CORE STRATEGIES: 1 LEADERSHIP

Daily Safety Huddle – adapted from Studer tools

- All hospital leaders gather for a 15 minute standing meeting to review safety issues.

SIX CORE STRATEGIES: 1 LEADERSHIP (AND DATA)

Administrative Restraint / Seclusion Spreadsheet



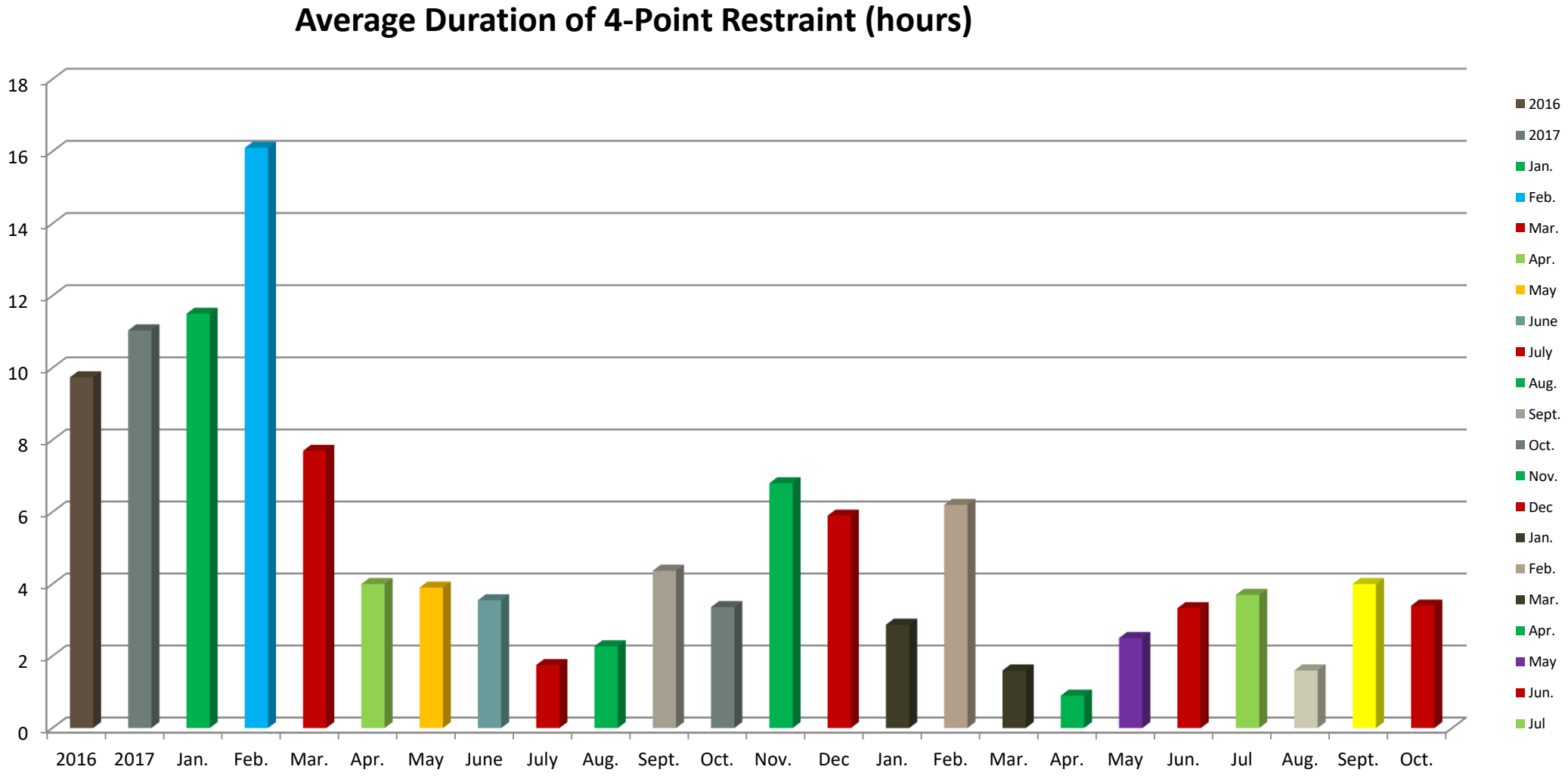
	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**Date**	**Initiated**	**Released**	**total time hours**	**Seclusion or Restraints (4-point or therapeutic hold)**	**Acct #**							
2	6/25/18	0	0	0									
3	6/26/18	0	0	0									
4	6/27/18	0	0	0									
5	6/28/18	1943	2343	4	4 pt								
6	6/29/18	0	0	0									
7	6/30/18	0	0	0									
8	7/1/18	0	0	0									
9	7/2/18	0	0	0									
10	7/3/18	0	0	0									
11	7/4/18	0	0	0									
12	7/5/18	0	0	0									
13	7/6/18	0	0	0									
14	7/7/18	0	0	0									
15	7/8/18	0	0	0									
16	7/9/18	1515	1700	1.75	4pt								
17	7/10/18	0	0	0									

SIX CORE STRATEGIES 2: DATA

Use of Data to Inform Practice

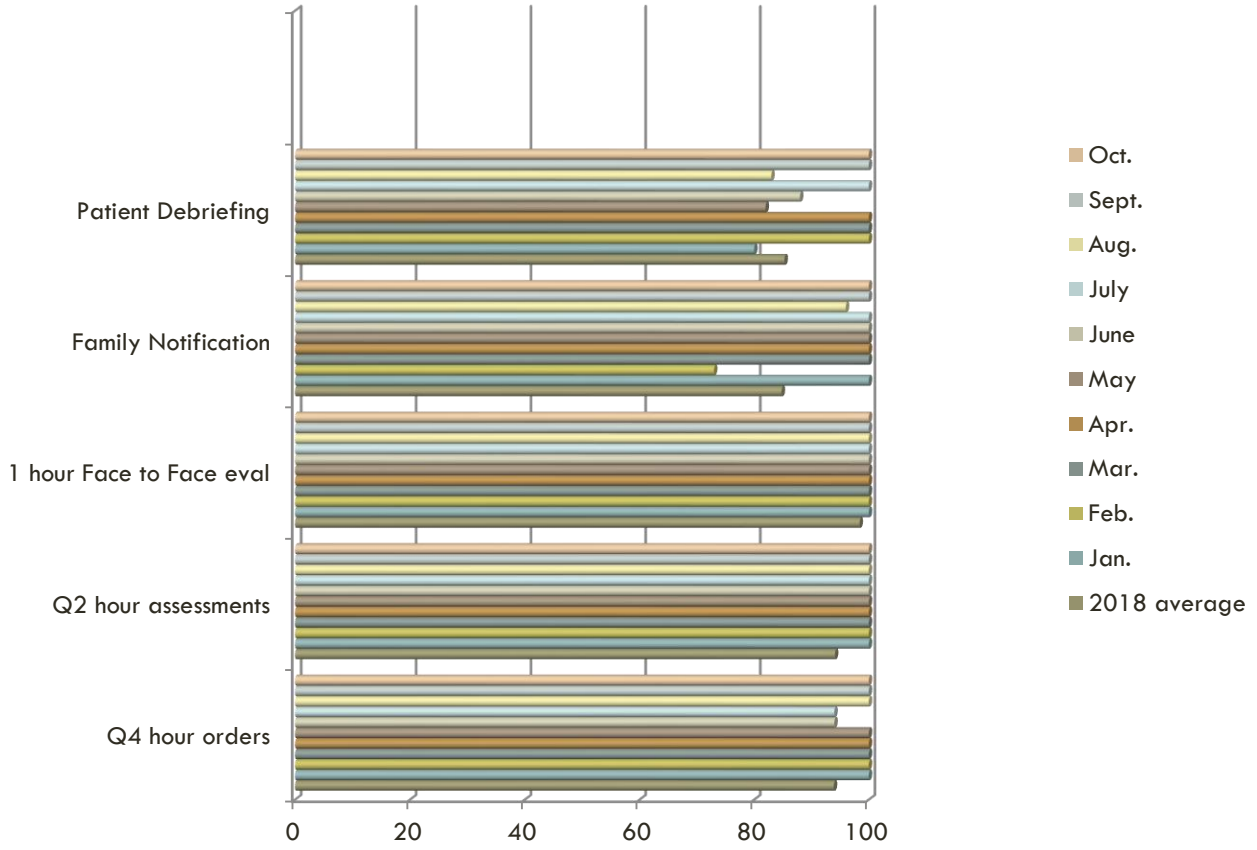
- Restraint and Seclusion reduction has been included in Quality Assurance goal setting each year.
- Data is tracked on 4-point restraint, locked door seclusion, chemical restraint and therapeutic holds
- Data is also maintained on restraint/seclusion documentation.

SIX CORE STRATEGIES 2: USING DATA TO INFORM PRACTICE



SIX CORE STRATEGIES 2: USING DATA TO INFORM PRACTICE

Restraint / Seclusion Documentation



SIX CORE STRATEGIES 2: USING DATA TO INFORM PRACTICE

Data reviewed by leadership, shared at staff meetings and posted on internal information boards.

Allows assessment of progress and needs

Allows staff to easily see results of change

Serves as starting point and basis for dialogue.

SIX CORE STRATEGIES 3: WORK FORCE DEVELOPMENT

This strategy suggests the creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma informed systems of care. The purpose of this strategy is to create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense is a core primary prevention intervention. This strategy is implemented through intensive and ongoing staff training and education Competencies. (NASMHPD, 2006)

SIX CORE STRATEGIES 3: WORK FORCE DEVELOPMENT

Interview questions

COAP at orientation

Annual R/S competencies

MOAB/SCM/CPI

Code Grey Training

Monthly training reviews at staff meeting

SIX CORE STRATEGIES 4: USE OF S/R PREVENTION TOOLS

- This strategy reduces the use of S/R through the use of a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan.

Relies heavily on the concept of individualized treatment.

Use of assessment tools to identify risk for violence and S/R history

Use of an universal trauma assessment

Tools to identify persons with high risk factors for death and injury

Use of de-escalation surveys or safety plans

Use of person-first, non-discriminatory language in speech and written documents

Environmental changes to include comfort and sensory rooms; sensory modulation interventions; and other meaningful treatment activities designed to teach people emotional self management skills.

A CLEAR RESPONSE PLAN

- When dealing with angry and hostile patients, a clear and well-coordinated response plan is something all staff understand and respond in concert to.
- Observe and understand roles and consumer reactions. Who has rapport? Who is the “trigger”?
- When providing information to those arriving during an ongoing situation, SBAR provides a concise and easy to understand framework for communicating critical information.

S SITUATION	What is happening?
B BACKGROUND	What is the clinical background?
A ASSESSMENT	What do you think the problem is?
R RECOMMENDATION	What do you recommend?

AVOIDING FORCE: DE-ESCALATION

- Verbal de-escalation strategies should be used whenever responding to crisis situations involving agitated and potentially aggressive people. The majority of escalated people can be effectively calmed through skilled verbal de-escalation.
- We will explore de-escalation in greater detail in the next section.

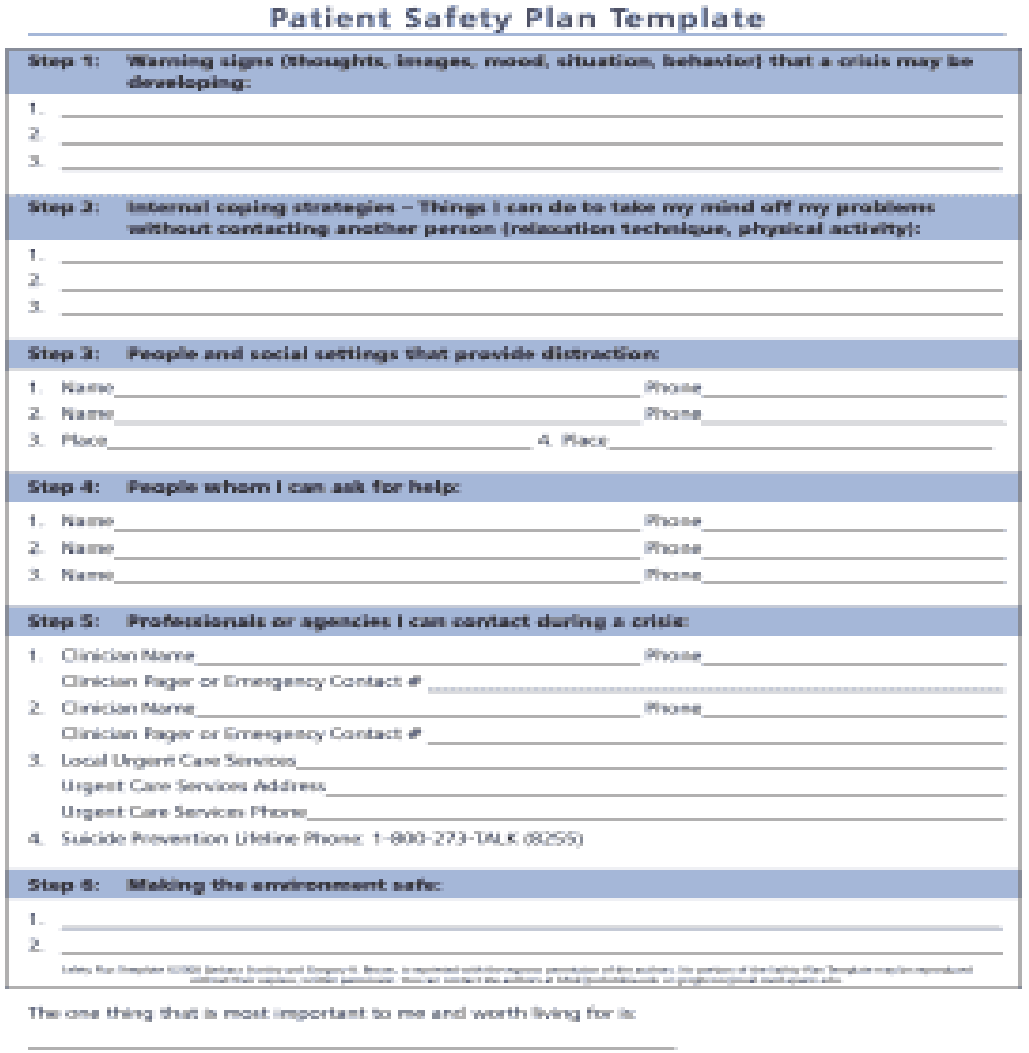
SHOW OF FORCE

In addition to skilled verbal de-escalation techniques, The Show of Force is a an invaluable strategy used to prevent S/R.

Show of Force requires a fast and reliable means of communicating the presence of a hostile situation as well as a willing and able workforce of responders.

SIX CORE STRATEGIES 4: USE OF S/R PREVENTION TOOLS

Crisis Tool and Safety Plan: Individualized assessment on admission, subsequent development of response plan for behaviors of concerns written in patient's own words.



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

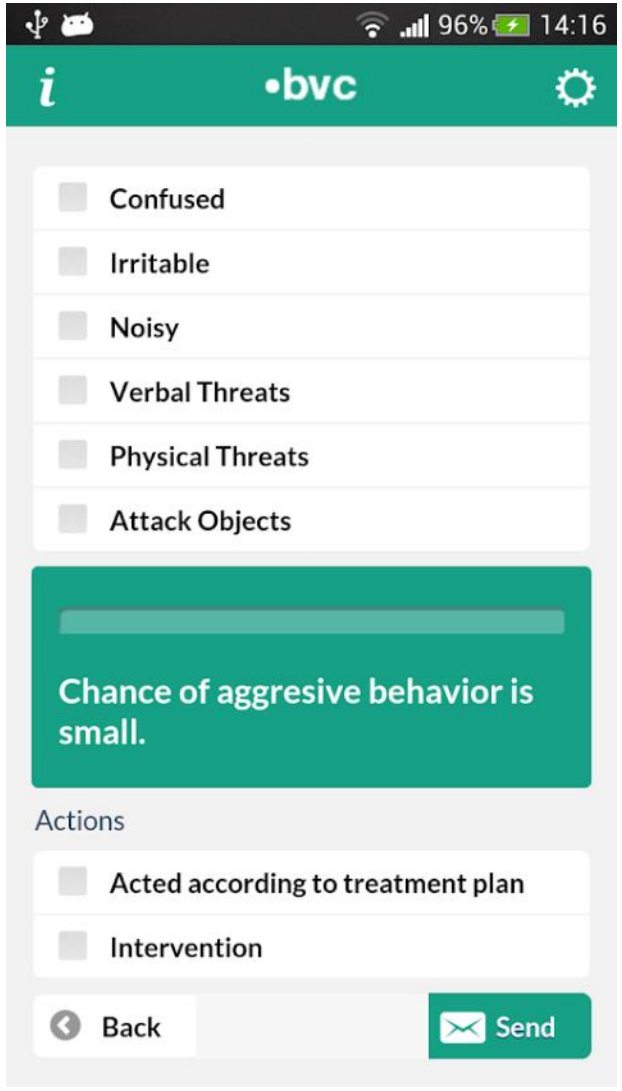
1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

SIX CORE STRATEGIES 4: USE OF S/R PREVENTION TOOLS

Broset Violence Checklist (BVC): a six item measure of patient behavior(escalation) taken at shift intervals throughout the day on each patient. Used as a predictor of violent behavior and as criterion referenced basis for PRN medication.



SIX CORE STRATEGIES 5: CONSUMER ROLES

This strategy involves the full and formal inclusion of consumers, children, families and external advocates in various roles and at all levels to assist. It includes consumers of services and advocates in event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees. It also involves the elevation of supervision of these staff members and volunteers to executive staff who recognize the difficulty inherent in these roles and who are poised to support, protect, mediate and advocate for the assimilation of these special staff members and volunteers (NASMHPD, 2006).

SIX CORE STRATEGIES 5: CONSUMER ROLES IN INPATIENT SETTINGS

Patient Safety Committee – Regularly scheduled review of key indicators measuring instances of aggression, safety metrics and established goals. Committee includes consumer and community representation.

Patient Satisfaction Team –To gather feedback on patient treatment experiences

SIX CORE STRATEGIES 6: DEBRIEFING

This core strategy recognizes the usefulness of a thorough analysis of each aggressive event. It values use of this knowledge to inform policy, procedures, and practices to avoid problematic outcomes in the future. A secondary goal of this intervention is to attempt to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and for all witnesses to the event (NASMHPD, 2006)

SIX CORE STRATEGIES 6: DEBRIEFING

Patient debriefing: Documented discussion with patient post-restraint. Development of a plan to reduce/avoid further restraint episodes.

Staff debriefing: Post-occurrence review of code and seclusion/restraint episode. Discuss concerns, ways to improve as well as to reinforce what worked well. Review of lead up to event. Develop safety plan going forward.

Daily Unit Safety Brief: Documented shift report distributed to all unit team members.

Event Reporting: Documented risk management report. Completed following behavioral codes and reviewed by department management and risk manager.

DAILY SAFETY BRIEF

4 PA SAFETY BRIEFING

Date: 1/30/19-1/31/19

Census 22

Violent Aggressive Patients:

*******- hx of. No issues this shift.**

**********- hx no issues**

**********- continues to be verbally aggressive and postures with Drs**

SI/SIB Patients Will Not Contract

None this shift.

Restraints/Seclusion/1:1

None this shift

Disorganized/Fall Risk Patients/delusional:

******** disorganized/paranoid. Improvement noted.**

*********- delusional/ RIS/ draws graffiti all over unit- no issues this shift.**

********- delusional/ believes she's dead. Monitor fluid intake. Encourage toileting. Urine culture pending**

Hx or Current Sexually Inappropriate Patients:

****

Patients moved to medical side and why/other:

none

Medication errors/near misses:

*********- brittle diabetic, we have issues with his blood sugars every shift. Please implement strict kitchen limits**

*********- methadone pt**

Vaccines given this shift

None this shift.

Elopement Risk

None this shift.

Environmental Safety Concerns on Units:

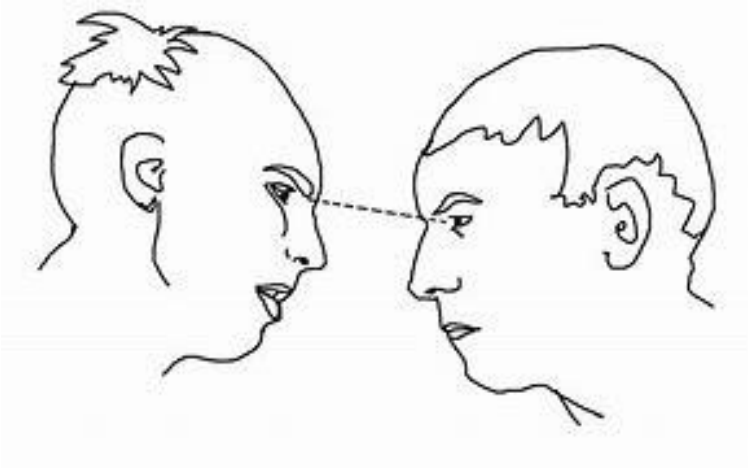
BVC's to be completed each shift.

Make sure you're consistent with 15 minutes and be visible on the unit.

Please monitor kitchen snacks.

Monitor pencils on the unit.

CONSIDERATIONS FOR CRISIS WORK



Crisis response in the community begins the treatment cycle

Crisis workers set the tone for consumer relationships with providers

Developing rapport and trust with consumers may lead to successful treatment outcomes after the handoff to the next level of care

Trust is earned. Crisis workers will likely have ongoing professional relationships with many consumers in their communities.

Interactions that culminate into aggressive outcomes set the stage for distrust and resistance.

Interactions that result in trust will yield dividends on future encounters.

SECTION 3

De-Escalation of Behavioral Emergencies

BEHAVIORAL EMERGENCY

PREVENTION AND EFFECTIVE RESPONSE BEGINS WITH UNDERSTANDING EARLY SIGNS OF ESCALATION.

- Restlessness, agitation, irritability, aggressive posturing and hostile comments signal escalating behavior.
- *Be aware. Assess the level of threat and intervene before symptoms become severe. De-escalation aims to prevent physical aggression and limit verbal hostility.*
- *In the event a patient does become physically assaultive, you should be prepared to respond in a manner that safely contains the behavior. Safe Crisis Management training is essential*
- *At all times, the dignity and rights of the individual should be maintained.*

A BEHAVIORAL EMERGENCY MAY INCLUDE AN INCIDENT OF "AGGRESSION" OR "POTENTIAL AGGRESSION":

Potential Aggression: *Consumer makes verbal threats to harm, acts in an angry manner, speaks loudly in a threatening manner.*

Aggression: H*itting, striking or purposeful destruction of property.*

RECOGNIZING WARNING SIGNS OF POTENTIALLY AGGRESSIVE BEHAVIOR

Appears tense, overly anxious or agitated

Makes threatening statements

Has intense glaring stares

Uses profane language

Is restless and demonstrates increased motor activity

Pacing and stomping

Mumbling

Shouting and screaming

Hand Wringing

ASSESSMENT OF BEHAVIORAL EMERGENCIES

- Some clinical presentations may increase likelihood of aggression:
  - Patients experiencing delusions and whom are frightened that someone or something is attempting to harm them may strike out as self-protective portion of the delusion.
  - Patients hearing voices (command hallucinations) may act upon the instructions of these voices and may strike out.
  - Sleep deprivation may distort perceptions and increase irritability and decrease control.
  - A troublesome history of institutionalization
  - Intoxication / Withdrawal

DE-ESCALATION

- Verbal de-escalation strategies should be used whenever responding to crisis situations. The majority of escalated patients can be effectively calmed through verbal de-escalation.
- Staff responding to the escalating patient should quickly assess the situation and speak in a patient, calm and supportive manner.
- In certain situations, reasoning with an enraged person may not be possible and in these situations, the first and only objective in de-escalation is to reduce the level of arousal so discussion is possible.
- Appear calm, centered and self-assured even though you don't feel it. Relax facial muscles and look confident. Your anxiety can make the person feel more anxious and that can escalate aggression.

STAFF REACTION

- *Skillful de-escalation is all in your response. The escalation or defusing of a person's behavior depends largely on how you react. Meeting anxiety with anxiety and defensiveness with defensiveness tends to accelerate crisis development.*

  - Don't be defensive even if even if the comments or insults are directed to you.
  - Don't defend yourself or anyone else from the insults.
  - Respond calmly and treat patient and family with respect
  - If consumer or family is uncooperative, try to identify the underlying reason, ask questions.
  - Provide choice and give options whenever possible
  - Explain intentions and promote accountability

DE-ESCALATING RESPONSE

- Use “I” or “We” statements
- Use non-verbal responses- i.e., nodding, open posture
- Encourage the patient to walk and talk, if applicable
- Set clear expectations
- Reinforce positive responses; “Thank you for letting me know your concerns”
- Listen, be attentive
- Offer choices if possible

- Don’t use “You” statements
- Avoid threatening posturing
- Avoid counter aggression
- Don’t take it personally
- Don’t defend yourself or others
- Avoid over reaction
- Avoid sarcastic responses
- Avoid using profanity
- Avoid arguing

DE-ESCALATION SAFETY

Maintain calm approach

Don't engage in a power struggle or make threatening remarks or veiled threats of any kind.

Don't try to challenge

Don't turn your back

Avoid being close enough to be hit

Stand at a side angle of the person in keeping a distance of at least one leg-length away. (About 3 feet)

Do not point, shake a finger or smile

Be aware of body language. Keep your hands in plain view. Maintain a relaxed stance.

Keep exit available and within reach

BE AWARE. EVERYDAY ITEMS CAN BE DANGEROUS

- *Lanyard, ties and scarves can be pulled around your neck*

- *Earrings can be pulled*
- *Be aware of lanyards/ name tags and glasses*

- *Are there things that someone can grab that can be used to hurt you?*

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