

Prevention and Management of Disruptive Behavior

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INTRODUCTION

Level I: Violence Prevention Awareness Training

The Prevention and Management of Disruptive Behavior (PMDB) program consists of four curriculum elements:

- Level I: Web-based Violence Prevention Awareness Training
- Level II: Observational and Verbal Skills
- Level III: Personal Safety Skills
- Level IV: Therapeutic Containment Skills

This web-based Violence Prevention Awareness Training focuses on identifying negative, potentially disruptive situations involving **affective** (emotionally-driven or impromptu) violence and introduces skills needed to resolve those situations effectively.

Level II: Observational and Verbal Skills

Learn and practice specific skills for identifying and verbally de-escalating disruptive behavior. This training course emphasizes early intervention to reduce the likelihood that situations will escalate to involving physical violence.

Level III: Personal Safety Skills

Learn escape and purely defensive techniques to minimize immediate danger and afford time to devise an appropriate response to situations involving physical violence. Remember: PMDB is designed to maximize the safety of patients and staff.

Level IV: Therapeutic Containment Skills

Learn to be part of a team able to contain a disruptive or violent individual physically with the least amount of harm to everyone involved.

Diversity in the Workplace

Our workplaces reflect our communities – we serve a wide range of patients and we ourselves come from diverse backgrounds. In dealing with each other, be aware that cultural values influence the way each one of us behaves. For example, they impact attire, hair, body language, and ways that respect is expressed. Sensitivity to these differences will promote a workplace at lower risk for disruptive behavior and contribute greatly to the environment of care.

Co-workers Experiences

Many of your co-workers have used techniques they learned in the PMDB Training Program to deescalate potentially disruptive situations.

Co-worker 1: I was interviewing a patient in my office and he suddenly grabbed my arm. I used the wrist release and then I told him “Sit down!” with a “stern mother’s voice” surprised us both and it worked! I don’t know how I would have handled it without this training.

Co-worker 2: Several months ago we had an incident at the front entrance. An intoxicated man came into the facility and grabbed one of the nurses. She had taken a PMDB class and knew how to get out of his grab. After she escaped she left the area and notified the hospital's response team. When I arrested him, I found he had a knife. I was really impressed with how well we worked together. I think everyone should take this course.

Co-worker 3: A while back I took a PMDB course with a bunch of other people. It was great. Then, a couple of months ago a patient grabbed me hard when I was going to the ER. And I was able to get out of his grab, and an officer was there and intervened while I called the response team. So I was able to help the patient get the right help and he always apologizes now when he sees me in the clinic.

NATIONAL PATIENT RECORD FLAGGING

The Patient Record Flagging section concerns the Veterans Health Administration only. If you are from another service, please proceed to the next section: Disruptive Behavior Continuum.

Introduction and Background:

Healthcare workers experienced the highest rates of non-fatal injury from workplace assaults of any occupational group in the United States. In 2001, over 12% of VHA employees and over 25% of VHA nurses experienced at least one assault. Because of this well known hazard, VHA initiated a broad-based program of violence prevention in the late 1970s. Over the last six years, VHA has reformatted the basic course "Prevention and Management of Disruptive Behavior"; implemented six years of Network Director Performance Monitors on violence prevention, including a national assessment of intervention effectiveness; and developed new materials on threat assessment and management.

Violence in healthcare is the subject both of formal guidelines from the Occupational Safety, and Health Administration (from 1996) and addressed in the Environment of Care and Leadership Standards from The Joint Commission (TJC). Knowing VHA's resources and prevention approaches is essential for safe work.

Development of Patient Record Flags:

The VA Office of the Inspector General (OIG) recommended that facilities communicate among themselves so that staff are aware of high-risk patients, regardless of where in the VHA system they may seek healthcare. National (or Category I) Patient Record Flags were developed in response to this recommendation. VHA Directive "National Patient Record Flags" governs the appropriate use of patient record flags.

VHA Use of Patient Record Flags:

The national behavioral flags represent VHA's core tool for alerting all staff about the risk for assaults from patients and providing guidance on appropriate action. A note 'behind' the flag contains detailed instructions on appropriate actions. PRFs help ensure the rights of all patients to receive confidential, safe, and appropriate healthcare and, at the same time, support a safe work environment for patients and employees. The risk of violence from patients can be mitigated by recognition, assessment, documentation, communication, and appropriate behaviors."

Rationale for PRFs:

In general, relatively few perpetrators commit the majority of assaults. One of the very few things that reduce assaults, along with general education and training, is letting employees know what triggers those behaviors and warns them on how to prevent recurrences. VHA achieves this notification through an innovative infrastructure: a behavioral flag in CPRS and, at each hospital, an accompanying Disruptive Behavior Committee to manage those flags.

Examples of events that commonly trigger the placement of behavioral patient record flags:

- History of violence toward staff/patients
- Documented acts of repeated violence against others
- Credible verbal threats of harm
- Possession of weapons or objects used as weapons

Disruptive Behavior Committee:

The group responsible for managing patient record flags is the Disruptive Behavior Committees (DBC) mandated at each facility. Those committees:

- Review assaults and incidents;
- Conduct threat assessments;
- Enter and manage the behavioral flags & associated progress notes.

These flags must be reviewed regularly so that they do not become outdated, and the associated progress note is intended to provide more extensive behavioral guidance to clinician's treating the patient.

The DBC is a multidisciplinary group comprised of representatives with expertise in mental health, safety, security, VA Police and other disciplines at high risk such as nursing or ER staff. The committee reports to the Chief of Staff, and is chaired by a senior clinical leader.

Flagging in the CPRS:

A Category 1 flag will pop up when the patient is selected in CPRS, but may also be accessed by clicking on the "FLAG" button. The flag advisory provides immediate behavioral guidance. The associated progress note, often summarizing prior notes, justifies the flag and provides more extensive behavioral guidance.

Example of a Justification Progress Note:

As of February 24, 20yy, it has been determined that this patient needs controlled healthcare. He has a history of credible threats of harm against staff, physical violence against a staff member, and behaving in a manner that disrupts the environment of care. Please see progress notes dated 7/30/yy, 9/19/yy, 9/22/yy, 11/17/yy, 1/29/yy, and 1/30/yy by authors A, B, and C.

DISRUPTIVE BEHAVIOR CONTINUUM

Any behavior ranging from annoying to violent is considered disruptive, if it threatens the safety of those involved, or appears to be escalating in that direction. If this happens, you might need to intervene to de-escalate the situation.

Causes of Disruptive Behavior

The causes of disruptive behavior are varied. Often, a patient who resorts to violence has experienced an actual or perceived injustice and, from their perspective, is attempting to “right a wrong.”

Fear

- Feeling uncertain or confused about present or future
- Anxious about aging

Frustration

- Waiting in long lines
- Being sent to one resource after another
- Feeling lost in a poorly marked building
- Dealing with paperwork

Intimidation and Manipulation

- Feeling pressured to make decisions
- Accepting inappropriate advice
- Agreeing to actions you aren't ready to take
- Using inappropriate pressure to get what you want

Poor Health

- Undergoing diagnostic testing
- Receiving results of tests

Pain

- Adverse medication effects
- Surgery recuperation

Memory Loss

- Head Injuries
- Strokes
- Dementia
- Age-related

Anger

- Not getting desired or needed information, services, or results

What About You?

If you're like most people, you can imagine a situation in which you would physically attack another to protect yourself or your family.

Have you ever slammed a door, kicked the wall or thrown something? We all have at least thought about it and may have actually done it when angry enough. It's important to remember that every one of us has the potential for violence in an attempt to regain control of what's going on around us.

A person exhibiting disruptive behavior, even if it's violent, can be influenced by intervention. Any disruptive behavior is fueled by what's going on inside – predisposing factors – and triggered by what's going on outside – precipitating factors. It never occurs in a vacuum. This is why recognizing your personal power to de-escalate a situation is so important. You are part of what's happening and you can dramatically influence the outcome. With a little training, you can personally turn a negative situation into a positive one.

PREVENTION AS A STRATEGY

Prevention is the key to avoiding escalation from the current situation into a more disruptive one. The ability to behave in a preventive manner is dependent upon the ability to assess yourself, the other person, and the environment, and understand the interactions among the three. Being alert to both predisposing and precipitating factors gives you a basis for decisions you will need to make about appropriate interventions.

The components of the assessment triangle are:

- Yourself
- Others
- Environment

Prevention

Your understanding of how human emotions work is critical. Appropriate interventions become second nature to you, not only in your professional life, but in your personal life as well. Here's what happened to one staff person trained in PMDB:

Several months after Jane finished the PMDB Training Program, she and her husband stopped during the middle of the day at a rest area off of a major interstate highway. While she was washing her hands in the restroom, a man attacked her from behind and got her in a head-lock. She remembered the class demonstration on protecting your airway by putting your chin in the crook of the attacker's arm, which she did. Knowing this was a true threat to her safety, she made herself a "noncompliant" target by kicking both her assailant and the trash can, making a lot of noise. After a few moments the attacker, perhaps deciding she was too much trouble, ran off. After this assault, Jane took the PMDB training again. She told her class instructors what she learned saved her life.

ASSESSMENT STRATEGIES

A work environment and the people who populate it are continuously changing. For everyone's safety, it is essential to develop assessment skills of the environment and other individuals, along with an increased self-awareness of your own responses to situations.

Assessment of Self

Reacting to a stressed or angry patient by becoming stressed or angry yourself is always a lose-lose situation. How am I reacting?

Is my tone of voice defensive? How's my body language – posture, eye contact, arms? Do I have a supportive stance? What do I look like to others? Is there someone in my personal space? Do I have any dangerous items – tie, scarf, large jewelry, stethoscope, scissors? Is my long hair or ponytail easy to grab?

Actions

- Use a calm voice.
- Keep your distance and maintain your personal space.
- Remove anything from your person that can be used as a weapon or can be grabbed by someone.
- Capture long hair in clips or tuck ponytails down the back of clothing.
- Maintain an open posture and non-threatening eye contact.

Awareness

- Pay attention to your “gut feeling” as an early warning sign.
- Communicating effectively with the patient depends upon being in control of yourself.

Assessment of Patient

A stressed or angry patient may be providing clues to his or her situation and level of stress.

What do you notice about physical appearance – hygiene or clothing neglected, appearing fearful, anxious, threatened, hostile or suspicious? What do you notice about personal behavior – pacing, clenching fists, slamming doors, pushing things, swearing, loud, language/behavior mismatch, exaggerating importance of self, sudden changes in behavior?

What do you notice about interpersonal behavior – blaming others, inappropriate approach or avoidance, nonresponsive to directions, challenging/threatening: “I’ll bet you don’t enforce this policy with anybody else!” Expressing intent to harm: “Some day soon she’ll get what she deserves.” Are there any dangerous items – potential weapons?

Actions

- A change in behavior from that which is typical or from earlier behavior is a strong indicator that something may be going on, indicating a need for verbal intervention.
- Any sign of increasing stress should be evaluated for potential loss of control.
- Assess the patient for potential weapons. Examples: crutches/canes extend their reach for striking; canes with knives in them.
- Become comfortable asking about weapons. If they have one, ask if they have others. Important: Know and follow your facility policy in securing weapons.

Awareness

- Most impromptu violent behavior is preceded by warning signs; often a good observer can see the buildup of tension and stress in the patient’s verbal and nonverbal behavior.
- Typically, people will state their intentions prior to acting out, though often they are not taken seriously by others until after a disruptive incident.
- Potential for being at high risk for disruptive behavior.

- Cultural differences, such as sense of personal space, significance of eye contact, and sense of time can impact the way you assess the situation. Be aware that what is “normal” in one culture may be interpreted differently in another.
- Generational differences, such as the mindset of people who lived through WWII, compared with those born since then. (Behavior may reflect values of stoicism but look like stubbornness.)
- Significant dates/anniversaries. These are unique to individuals. Be aware of a patient’s history pertaining to dates or significant military or personal experiences.

Assessment of Environment

The environment in which you encounter patients also requires assessment.

Are there any potential weapons – staplers, letter openers, paper weights, vases, coffee mugs? How is the arrangement of the furniture – is it difficult to reach the door quickly? What about available exits – is there only one, blocked by anything? Is there confusion, noise or overcrowding – too many people, potential “audience” for a disruptive situation? Is the temperature of room at an extreme? Anything about the time of day if there’s a shift change – fewer available staff than usual?

Actions

- Assess your work areas on a regular basis. Put away or take home heavy objects which could be used as weapons.
 - Set up offices and exam rooms so that the patient is never between you and the door. Do not try to stop an angry patient from leaving the room.
 - Adjust the temperature to accommodate the widest range of people.
 - Isolate the situation, not yourself. Create an acceptable “out” or solution for the angry patient and/or remove the “audience” so you don’t have to deal with “group think.”
 - Two ways:
 - 1) Request the patient move to a quieter place so someone can “provide assistance.” Be flexible about altering original schedule or process, if necessary. Let a team member know what’s happening and where you will be. Stay near other staff, not at the end of an isolated hall.
 - 2) Remove the other patients or visitors in the area or divert traffic from that area.
- Important: Know and follow your facility policy in securing weapons.**

Awareness

- Note exits and emergency phone numbers if you change work areas.
- Confusion, background noises, and crowding increase stress levels.
- There is an increase of disruptive behaviors during meal times, shift changes, and while transporting patients.
- Parking can be a significant stressor, especially at large facilities.
- Current events – economy, world events, holidays, financial stresses, organizational changes, layoffs
- Seasonal changes and natural disasters – hurricanes, tornadoes, earthquakes.

PREDISPOSING FACTORS: INDICATORS FOR DISRUPTIVE BEHAVIOR

Predisposing factors are individual characteristics, including influences from the past that we bring into a situation. Learning what these are when a potentially disruptive situation is occurring, should lead to better decisions about the need for intervention. While each person in the environment is impacted by his or her own predisposing factors – including you – this tutorial focuses on what you might learn about a patient in particular. There are two categories of predisposing factors that may contribute to disruptive behavior:

- Individual characteristics
- Diagnoses associated with violence

Personality traits to look for include: loner/withdrawn, poor interpersonal skills, suspicious of others, blames others for problems, low frustration tolerance/impatient, frequent mood swings, views world as hostile/threatening, perceived loss of options, problem with authority figures, shows disregard for safety of coworkers.

A person's history may indicate potential problems: poor employment history; health problems – cancer, head injury, disability; substance abuse; history of past violence – past behavior is best predictor of future behavior; history of exposure to domestic violence or breakdown of the family unit.

Hobbies or interests that might indicate a problem include: a fascination with violent music, games, movies; a fascination with homicidal incidents in the workplace and/or empathy for those who commit acts of violence; an obsession with weapons.

Actions

- Look for these characteristics every time you interact with others.

Awareness

- One or two characteristics may not be as high a risk factor as having several characteristics.
- Not all violent individuals are mentally ill and not all mentally ill individuals are violent.
- Some of the possible consequences for a patient exhibiting these characteristics include being shunned by coworkers, economic instability, psychiatric commitment, jail, or homelessness.
- 4-10% of patients cause 4080% of injuries.
- A young male growing up in a fatherless home is 11 times more likely to commit a violent crime.
- Domestic violence spills over into the workplace. Inform your facility security, police or supervisor if domestic violence is a personal concern.

Diagnoses Associated with Disruptive and Violent Behavior

Anyone can become violent or disruptive, but some diagnoses should alert you to a greater potential for risk.

The following are diagnoses followed by examples of how they might be expressed by a patient.

Intoxication or substance abuse: signs of current usage or history of abuse.

Delirium: rapid changes in cognitive abilities.

Schizophrenia: delusions and hallucinations with violent content.

Major depression: expressions of hopelessness and helplessness.

Bipolar disorder: manic behavior and loss of control.

Post traumatic stress disorder: impaired problem-solving skills and heightened anxiety.

Cognitive disorders: dementia and altered mental status.

Traumatic brain injury: impaired cognitive abilities and emotional ability.

Intermittent explosive disorder: loss of control over aggressive impulses.

Conduct disorder and antisocial behavior: childhood and adult disorders that may include aggression.

Attention deficit/hyperactivity disorder: acting out and very poor impulse control.

Borderline personality disorder: lack of emotional response or over-exaggerated response; may turn hot or cold depending on whether they are getting what they want; may use anger to manipulate or intimidate.

Antisocial personality disorder: lack of emotional response or an over-exaggerated response; may be very personable and charming, but have no regard for anyone but themselves.

Actions

- Maintain a high level of alertness.
- Inform patient's provider of changes in, or worsening of symptoms.

Awareness

- Be aware that disruptive behavior is often a sequela (an aftereffect of disease or injury) of these disorders.
- Some – but not all – individuals with these diagnoses may be at increased risk for disruptive or aggressive behavior.

PRECIPITATING FACTORS: INDICATORS FOR DISRUPTIVE BEHAVIOR

Precipitating factors are the triggers that are inherent in a particular situation or are introduced into a situation and impact a patient already predisposed to respond disruptively. You have the power to defuse the impact of a precipitating factor.

For example: A patient arriving late due to parking problems may indicate by manner or words this has increased their stress level.

If you ignore or trivialize the irritation, even though you may have no control over the parking situation yourself, you have lost an opportunity to defuse the situation. On the other hand, if you respond, either nonverbally or verbally, acknowledging the irritation with genuine empathy, you have a good chance of averting potential escalation.

Precipitating factors in any customer service workplace

If you work with people in a customer care/service profession, many things about your workplace may be precipitating factors.

For example: The environment: rain, snow, heat, cold, rude strangers. The type of staff interaction: perceived lack of empathy, care or concern. Excessive noise: sounds that may not be offensive to most, such as music, may agitate others. Convenience of service: waiting times,

confusion in waiting area, incompatibility with others who are waiting, being sent from place to place to receive service. The behavior of family members: someone angry with spouse, child, parent. Outdated or inaccurate signage: insufficient, difficult to read. Disruption caused by construction or organizational changes. Traffic and parking: inadequate parking, dangerous traffic flow.

Actions

- Acknowledge and show empathy for the frustration the patient is feeling.
- Inform appropriate resources so that environment of care can be improved.

Awareness

- Stress over days, weeks, or months may accumulate in any of us. As we each react to stress differently, it's possible that an environmental trigger may "light a fuse," thereby increasing the potential for violent behavior.
- These factors can impact nearly any workplace.

Precipitating factors in medical center procedures

If you work with people in a medical center, there will be even more things about your workplace that may be precipitating factors.

The lack of privacy: no private areas to discuss personal/confidential information, conduct physical examinations.

The loss of dignity, independence and control: right away the patient has to take off all their clothes and wear a gown or pajamas.

The loss of identity: coworkers refer to individuals by problems, diagnoses, room numbers.

The fear of pain: fear of what may occur during an exam, testing, surgery procedure.

Frustration with the system: having to take a number.

Actions

- Refer to patients by name and not by their medical problem.
- Take time to talk with the patient and explain what is happening.
- Make sure that you and others are treating the patient with dignity.

Awareness

- Remember what it feels like to be a patient, especially in a medical center setting.

HUMAN EMOTIONS UNDER STRESS

With very few exceptions, all humans share the same potential for a full range of emotional experience and expression.

Six stages are detailed here:

- 1) You have the potential ability to experience and express a full range of emotions in their true form. So does everyone else.
- 2) Managing our emotions and the way we express them is an important part of fulfilling our social contract with others and part of normal development. We are not free to express anything we feel at any time.
- 3) Sometimes we overdo it when we manage our emotions, going beyond merely regulating them to actually shutting them down.

4) Although this “numbing strategy” might keep you safe during a trauma, surviving an abusive family, or avoiding a fight, it can have unwanted consequences if used in all situations. Avoiding emotions in their true form can become a habit very easily, especially if experiences in relationships, jobs, or the military teach us that expressing certain emotions in their true form is socially undesirable.

5) Emotional energy, once generated, HAS TO GO SOMEWHERE. Blocking an emotion’s true channel of expression does not eliminate that emotion. Where does that emotional energy go?

6) Blocked emotional energy will bounce around until it finds an open channel of expression. Anger happens to be a common way for blocked emotional energy to be expressed.

LEVELS OF STRESS

Description of Levels

Understanding the five levels of stress will increase your ability to assess yourself and the patient in any potentially disruptive situation.

First Level – Normal: This level of anxiety is a part of day-to-day living.

Second Level – Moderate: As stress increases, the perceptual field decreases, becoming limited to the immediate task at hand.

Third Level – Severe: The perceptual field decreases even more as stress continues to increase.

Fourth Level – Panic: This is the most intense and destructive level of stress.

Fifth Level – Tension Reduction: This is the de-escalation phase, a return to a normal level of stress.

A patient with a high potential for disruptive behavior may experience these levels a little differently, and be vulnerable to escalating more quickly than you might expect.

Intensity of Levels

The way we feel and show stress varies with the individual and the situation. However, the relative intensity of stress levels can be compared and some general observations made.

Level of Stress – Normal

Normal stress sharpens the senses, increases motivation, and may enhance performance on routine activities. At this level of anxiety, we are the most alert and the perceptual field is actually enlarged, promoting optimal functioning. At this stage, we see, hear, and grasp more stimuli, enabling us to solve problems and learn effectively. Our perceptual field is keen, we can take in the entire environment and process information.

Level of Stress – Moderate

The person is focused on the here and now and does not take in as much outside information. They may not even hear information you are providing. Their perceptual field narrows, they are focused on here and now, and there is a decrease in information intake.

Level of Stress – Severe

The person experiences tunnel vision, not able to focus on more than one thing. Information processing is nearly impossible and complex motor skills will be deeply impaired. Their

perceptual field is limited and they are focused on one thing with tunnel vision. Processing of information is severely limited and complex motor skills deteriorate.

Level of Stress – Panic

The perceptual field, focused only on self, is so limited that the person is no longer able to process any outside stimuli. This person is at high risk for violent behavior. Feelings of anger, fear, or helplessness may emerge explosively. A "fight or flight" reaction may occur. Warning signals include: clenched fists, walking briskly, continuous pacing, throwing items, exaggerated response to annoyance, yelling, pressured and curt speech, quivering of the lips, rigid muscle tension, and biting or scratching. They are focused intently on themselves, their uncomfortable feelings, and whatever they are angry or fearful about. If someone becomes a physical threat, follow your facility procedures for personal safety skills and/or therapeutic containment. Their perceptual field is very narrow, they are unable to process information or problem solve. They may be dangerous to self or others.

Level of Stress – Tension Reduction

Though you may never see this patient again, someone else will. For this reason, your actions to develop rapport with the patient will protect his or her dignity, helping to "save face" and smoothing the way for future interactions. The goal in tension reduction is to assist a patient in identifying what triggered the acting out and to troubleshoot how to prevent its recurrence. Through the whole process a calm, reassuring approach will assist the individual in returning to a normal level of stress. They are returning to their normal level when their perceptual field will again be keen, they will be able to take in information. This stage takes time.

STAFF INTERVENTION

Understanding the different levels of stress and their symptoms helps in early intervention, which you can employ at any level of stress. The type of intervention you choose will depend, at least in part, on your assessment of the patient's stress level.

The goal is always to maintain rapport with the patient. This includes matching the intensity of your response to the intensity of the event.

Normal Stress Level – Customer service

Moderate Stress Level – Verbal and non-verbal intervention

Severe Stress Level – Limit Setting

Panic Stress Level – Personal safety skills and/or therapeutic containment

Tension Reduction Stress Level – Therapeutic rapport

Non-Verbal Interventions

The single most important nonverbal communication you can convey is empathy. A genuinely warm and caring attitude allows an individual to be heard and understood. It can be very effective in de-escalating a potential crisis. If your usual demeanor is not one of empathy, attempting to express it during a crisis may be very difficult.

Actions

- Be in a supportive stance to facilitate the use of personal safety skills if these become necessary.

- Be calm. If you can't be calm, act calm. Keep eye contact, smile, and keep hands open and visible.
- Listen. Nod your head to demonstrate that you are paying attention.
- Respect personal space. Maintain arm/leg distance away from individual. Avoid touching an angry patient as it may be misinterpreted.
- Approach the patient from an angle or from the side.
- Convey that you are in control, by demonstrating confidence in your ability to resolve the situation.
- Demonstrate supportive body language. Avoid threatening gestures, such as finger pointing.
- Avoid laughing or smiling inappropriately.

Awareness

- Anxiety triggers or escalates anxiety.
- Crutches, canes, and walkers extend beyond arm/leg distance away from an individual but are still considered part of personal space.
- Approaching a patient straight on may be perceived as confrontational.

Verbal Interventions

In conjunction with nonverbal communications that convey empathy, your words can impact a potentially disruptive situation, leading to reduced stress and safety for all concerned.

Giving recognition: "Good Morning, Mr. Thompson."

Accepting: "Uh hum, I follow what you said."

Offering self: "I'll sit with you awhile."

Asking open-ended questions: "And then? Tell me about it."

Placing the event in time or in sequence: "Was this before or after you called here?"

Making observations: "You appear tense. I notice that you're biting your lips."

Encouraging comparison: "Have you had similar experiences?"

Restating: Patient: "I can't sleep. I stay awake all night." Nurse: "You have difficulty sleeping."

Focusing: "I can understand how frustrated you must be let's focus on getting this resolved."

Giving information: "Mr. Jones, I'm here to explain the procedure you're about to experience."

Seeking clarification: "What is the main thing you would like accomplished?"

Presenting reality: "I see no one else in the room. That sound was a car backfiring."

Seeking consensual validation: "Tell me whether my understanding of it agrees with yours."

Actions

- Develop your use of a variety of verbal interventions for potential situations.

Awareness

- Be aware of your tone of voice and body language and what's going on around you, as well as your choice of words.

Alternative Interventions

Suggesting an activity that requires movement, if only from one area of a room to another, may serve to de-escalate the situation and provide the opportunity for nonverbal and/or verbal interventions. Medication may be appropriate for some patients.

Actions

- Walking
- Working out in the gym
- Offering a cold beverage
- Turning on some music
- Guided relaxation/visualization
- Exercising
- Moving to a designated “Quiet Room”
- Medication

Awareness

- A hot beverage, such as coffee, can be used as a weapon.
- Music that relaxes one patient may do the opposite to another.
- Relaxation/visualization exercises are much more effective if they have been learned and practiced during periods of less stress.
- The use of a punching bag may actually escalate the stress.

LIMIT SETTING

Limit setting techniques place some external control on the situation when a patient’s stress level increases from moderate to severe, thereby lowering the stress, and facilitating decision-making.

A common misunderstanding is to confuse setting limits and issuing threats. Setting limits de-escalates; threats signal the patient that the situation is more hopeless than they had perceived, and may precipitate a violent crisis. What you say must be believable. There is a difference between telling someone “Go sit in that chair so I can get on the phone to help you,” and “If you don’t shut up, I’m going to put an IV in your arm.” A threat tends to be unenforceable, and the patient may well react to this evidence that you are out of control yourself. Your awareness of yourself is critical, and learned behaviors that reduce your own stress are essential. You must remain rational in an emergency.

Actions

- Breathe deeply, and assess your own level of stress.
- Know your facility’s procedure for getting immediate assistance.

Awareness

- You may perceive the encounter as a power struggle that you want to win.
- It’s better to recognize your need for assistance and get help than to get involved in a power struggle.
- Initiating your facility’s procedure for immediate response to disruptive/violent behavior may be indicated.

FACTORS

The following short stories ask you to identify what the patient brought to the situation that predisposed them to disruptive behavior, and what the situation presents that acts as a trigger, precipitating potential escalation.

K.G., a 42 year-old married woman, whose husband is deployed with the military overseas, cares for her two children and aging mother with no local family support. Earlier in the afternoon her 81 year-old mother received a compound fracture when she fell down the stairs and was admitted to the hospital. K.G. comes with her two children, ages 8 and 10, to visit her mother. The charge nurse informs the mother that the two young children are not old enough to be on the unit. The mother and nurse argue. The two young children become increasingly disruptive. The mother begins crying uncontrollably. The hospital chaplain arrives on the scene and the distraught mother turns to him for assistance. The charge nurse continues to maintain her position despite pleas from the chaplain.

C.J., a 38 year-old patient who is on oxygen, has been rather unpredictable in the last several months and was recently diagnosed with terminal lung cancer. His birthday just passed and no one from his family came to visit. C.J. is told he is not able to go outside and smoke until the designated "smoke time." Several hours later, feeling frustrated, he is finally able to go out and smoke. A maintenance person overhears him threatening to blow himself up.

R.M., a 62 year-old patient, has a history of drug-seeking behavior. He has serious injuries from a motorcycle accident and a legitimate prescription for pain medications. Several years ago R.M. was arrested for trading prescription medications for illegal street drugs. He comes to his primary care clinic without an appointment demanding another prescription for his pain medications. He tells the clerk he requested a 60day supply but received only a 30day supply. R.M. is informed that his primary care physician is unable to see him that day. He leaves the clinic and goes to see the medical center director, then the patient advocate, and finally, Mental Health.