

Collaborative Safety Strategies

Annual Inpatient Review Training Program

Participant Handbook



State of Connecticut
Department of Mental Health and Addiction Services
Division of Safety Services,
Safety Education and Training Unit
July 2012

CSS Annual Inpatient Review Updated References and Suggested Reading

The complete reference list for Collaborative Safety Strategies Training Program can be found on our website. This list provides the updated references used for the FY13 CSS Inpatient Review.

Risk Management

1. Anderson A, West S: Violence Against Mental Health Professionals: When the Treater Becomes the Victim Innovations in Clinical Neurosciences March 2011: 8 (3) 34-39.
2. Gillespie GL, Gates D, Miller M, Howard P.,: Workplace Violence in Healthcare Settings: Risk Factors and Protective Strategies. Rehabilitation Nursing Vol35,No.5. September/October 2010.
3. Sculli GL, Sine DM: Soaring to Success; Taking Crew Resource Management from the Cockpit to the Nursing Unit. HCPRO 2011, Chapter 6
4. Tesar GE: Psychiatric Emergencies. Retrieved from www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/psychiatry-psychology

Strategies for Enhancing Safety and Interrupting the Cycle

1. Short R, Sherman M, Raia J, Bumgardner C, et al: Safety Guidelines for Injury-Free Management of Psychiatric Inpatients in Precrisis and Crisis Situations. Psychiatric Services, December 2008, Vol.59 No. 12

Safety Strategies for Escalating and Crisis Situations

1. Moylan LB: Physical Restraint in Acute Care Psychiatry. Journal of Psychosocial Nursing Vol.47, No. 3, 2009 41-47.
2. Papadopoulos C, Bowers L, Quirk A, Khanom H: Events Preceding Changes in Conflict and Containment Rates on Acute Psychiatric Wards. Psychiatric Services January 2012, Vol. 63 No.1 40-47.
3. Alternatives to Restraint and Seclusion in Mental Health Settings: Questions and Answers from Psychiatric Nurse Experts. Obtained from www.medscape.com/viewarticle/555686 September 14, 2011.

This Collaborative Safety Strategies Participant Handbook is intended exclusively for use by DMHAS employees during attendance at the CSS Inpatient annual Review class that is taught by certified Division of Safety Services Instructors.

DMHAS employees may use it as a reference tool but because it is not all inclusive of the content and techniques that are taught during a CSS class, it should not be used exclusively to address questions related to it's content.

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TABLE OF CONTENTS

Module 1: Overview

Overview 1
Learning Objectives 2

Module 2: Creating Safe and Therapeutic Environments

Creating Safe and Therapeutic Environments 4
Four Aspects of Safety 5

Module 3: Protective Physical Skills

Photos: Ready Stance, Protective Posture, Blocks, Chokes 6

Module 4: Risk Management

RM Process and R/S defined 10
Clinical Risk Assessment and Analysis 11
Patient Risk and Protective Factors 11
Staff Risk and Protective Factors 13
Triggers 13
Warning Signs 15
Assessing and Determining the Level of Risk 15

Module 5: Strategies for Enhancing Safety and Interrupting the Cycle

Communication Barriers 17
Non-Emergency and Emergency Planning 18
The 3 W's 19
Verbal Interventions 20
Other Therapeutic Interventions 21

Module 6: Managing a Crisis involving the use of R/S

Team Approach 23
Preventing Restraint Related Injury and Death, A-E model 24
Photos: Escorts, Third and Fourth Person Assists and Takedowns 26

Module 7: Strategies for Escalating and Crisis Situations

Least to Most Restrictive Physical Interventions Flow Chart 30
Underlying Principles for the use of R/S 31
Intensive care for the Patient in R/S 31
Release from R/S 32
Intensive care for the Staff 33
Debriefing 33
Documentation 34

Updated References and Suggested Reading

Debriefing Others

Always consider the impact of these emergencies on others who may have witnessed the violent behavior, or who know about it and may be impacted in some way, including experiencing vicarious trauma. This is an excellent time to call an emergency Community Meeting to address the concerns of others and to reassure them that they are safe. Pay special attention to the persons roommate(s) and meet with the as needed to provide reassurance. The Community Meeting may also provide information about what was happening prior to the crisis that you didn't know about.

Finally, the Treatment Team must meet with the patient to review the incident in detail and consider changes to the Plan. Make sure that you communicate what happened, what worked or didn't and any new information about the patient that would help redevelop the plan. Again, the revised plan should address all the aspects of after care that we talked about earlier.

Documentation

Make sure that the following information is documented in the patient's medical record:

What happened **prior** to the use of R/S?

- The condition or symptoms) that warranted the use of R/S
- The response to all of the interventions) attempted, including the rationale for continued use of the intervention
- The rationale for the type of restraint or seclusion used

What happened **during or immediately after** R/S use?

- The 1 hour and any other face to face medical and behavioral evaluation;
- Notification of the individual's family/conservator/legal advocate, when appropriate
- Written orders and telephone orders for use
- 15-minute assessments of the individual's status
- Assistance provided to help patient meet the behavioral criteria that was identified for discontinuation of R/S
- Continuous monitoring
- Debriefing of the individual with staff
- Death or injuries that are sustained and treatment received for these injuries

Staff injuries are documented using the Worker's Compensation Injury Forms. Follow your facility policy for any other specific forms that are used.

Intensive Care for the Staff involved in R/S Situations

Being involved, either directly or by witnessing restraint or seclusion related emergencies may be traumatizing. Staff that are directly involved or who witnessed the emergency can experience vicarious trauma. Signs and symptoms include*:

- Difficulty managing your emotions; e.g.: depressive symptoms, pessimism, cynicism, fatigue, specific somatic problems, irritability, anxiety, guilt
- Difficulty accepting or feeling okay about yourself
- Difficulty making good decisions
- Problems managing the boundaries between yourself and others (e.g., taking on too much responsibility, having difficulty leaving work behind at the end of the day, trying to step in and control other's lives)
- Problems in relationships
- Physical problems such as aches & pains, illnesses, accidents
- Difficulty feeling connected to what's going on around and within you
- Loss of meaning and hope
- Poor performance at work, absenteeism, avoiding restrictive interventions. It's important to take care of yourself and each other when these crises occur.

Staff Debriefings

Always debrief immediately after – the Team Leader is responsible for making sure it happens and may lead the debriefing, or have another person who is aware of what happened conduct the staff debriefing.

- Immediately assess if there are any physical injuries
- Immediately assess the emotional status of all involved and
- Support each other and use additional supports to decrease the risk or signs of trauma. Use EAP, CISM, Staff meetings, Supervisory support and Others e.g. Chaplain to decrease the risk of trauma.

Then briefly discuss what worked - in terms of the roles, responsibilities and mechanics of techniques used - and what didn't work. Make sure the information is incorporated into the plan that's developed for the patient upon release from R/S.



*<http://www.headington-institute.org>. Self Study: Understanding & addressing Vicarious Trauma.

Release from R/S

The main criteria for release from R/S is that the person no longer poses an immediate risk of violence –again, think about the scale – the risks of remaining in either R/S now would outweigh the risks of release from R/S. Typically, you will observe that:

- Cognitively, there is a decrease in their focus, hostility and suspicion related to what triggered the behavior.
- They will be less aroused - irritability and intensity of emotions should be decreased.
- Impulsivity, verbal aggression, physical aggression, physical tension should be decreased. If they have had medications or used other methods to become calm, you should see fewer or decreased diagnostic symptoms e.g., agitation from psychosis.

When you are able to talk with a patient who is in R/S to debrief and help them meet criteria for discontinuing, the focus of the conversation is on the specific criteria. This is not the time for more in-depth, insight gaining discussions. That can and should occur after R/S discontinued.

Remember that waiting too long to use R/S can have negative outcomes, so can releasing too early. Make sure that the criteria are met. There's always a risk of reoccurring dangerous behavior, but if the criteria is met and there's a plan in place, the risks should decrease.

After Care of the Person who has been released from R/S

Using the intensive care medical model, after a patient has been released from R or S, they should still be monitored closely. You should be viewing the person as a short term continued risk and put a plan in place that reduces the likelihood that they will re-escalate. The patient should be aware of the plan – and whenever possible, should participate in developing it. It should address all the elements of the non-emergency plan that were reviewed earlier e.g., interventions, activity, structure, etc. (page 19).

Underlying Principles for the Use of Restraints or Seclusion

These underlying principles are important in your decision making process and always must be considered:

- They are only used for the management of violent or self- destructive behavior that jeopardizes the immediate physical safety of the pt, staff or others.
- They are not used for coercion, discipline, convenience, retaliation or as physical or mental abuse or corporal punishment.
- All pts have the right be treated in a safe environment and to be free from all forms of abuse or harassment.
- All employees have the right to work in a safe environment.
- The risks of not intervening are greater than the risks of intervening.
- Choice of intervention is least restrictive.

Intensive Care for the Patient in R/S

The use of restraints or seclusion doesn't end the crisis, it's only the point at which the violence is contained. In fact, the interventions that you have to use until the patient is behaviorally safe (out of R/S) are much like an intensive care unit in a medical hospital. That means that you must provide a high level of care and monitor the patient closely per individualized assessment and R/S Policy – constant observation is typical.

While monitoring, you must minimally:

- Continuously reassess physical, medical, emotional and behavioral condition i.e.,
 - Signs of injury associated with R/S use
 - Nutrition and hydration
 - Circulation and ROM
 - Vital Signs
 - Hygiene and elimination
 - Physical and psychological status and comfort
 - Patient specific concerns
- Use your facility specific flow sheets and policy's for other monitoring requirements.

Communicate concerns immediately to licensed medical staff. Take all complaints of pain, discomfort seriously – and have them immediately medically evaluated.

Debrief with the patient about what just happened. Provide reassurance and the specific criteria for discontinuing R/S; then work with the patient to meet the criteria based on your assessment e.g., in an extremely agitated or psychotic patient, some quiet time or music or other calming activity may be helpful. Find out from the patient, what would help them calm down and regain behavioral control.

Overview

Workplace violence is defined by the state of CT as any physical assault, threatening behavior, or verbal abuse occurring in the work setting.

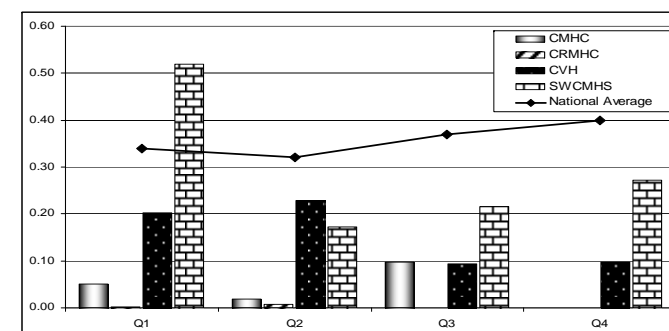
A **workplace** may be any location either permanent or temporary where an employee performs any work-related duty. This includes, but is not limited to, the buildings and the surrounding perimeters, including the parking lots, field locations, clients' homes and traveling to and from work assignments.

It is well documented, that nursing staff in in-patient settings, particularly public sector psychiatry, are the most likely to be attacked and face a greater risk of occupational injury from violence alone than workers in other high risk occupations.

The US Dept. of Labor, reported in its News Release Nov. 9, 2011 a high incidence rate for nonfatal occupational injuries involving days away from work for all health care and social assistance workers as a result of assaults and violent acts. Note that the data does not indicate if the statistics are patient related, nor is it separated by setting type e.g., psychiatry. Still, other literature supports findings that injury rates from patient assaults are high, especially in public sector mental health settings.

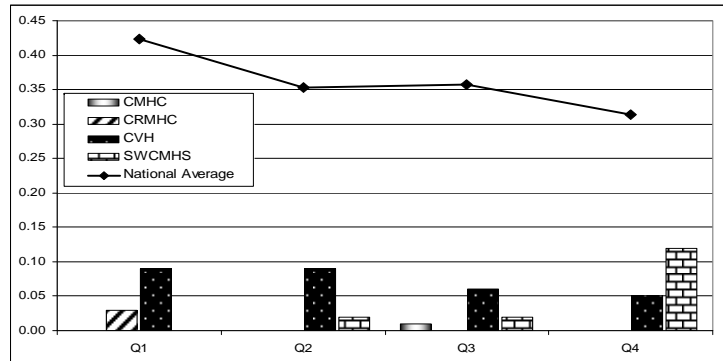
When compared to the national average, DMHAS, restraint and seclusion rates and hours (per 1,000 patient hours) are lower than the national average. The rate of restraint and seclusion use is based on the number of hours in restraint per patient hours by calculating the number of patients and their length of stay into account. The hours are calculated per 1,000 patient hours.

This chart shows the **rate** of restraint use in our mental health and substance abuse beds for FY 11 as compared to the national average:



Note that 13 of the 26 restraint events during the first quarter at SW were attributed to one client.

This chart shows the **rate** of seclusion use in our mental health and substance abuse beds for FY 11 as compared to the national average.



A review of Workers Compensation data from 2007-2010 shows a downward trend in days lost from physical assaults and restraint activity with the greatest reduction in days lost from Physical Assaults.

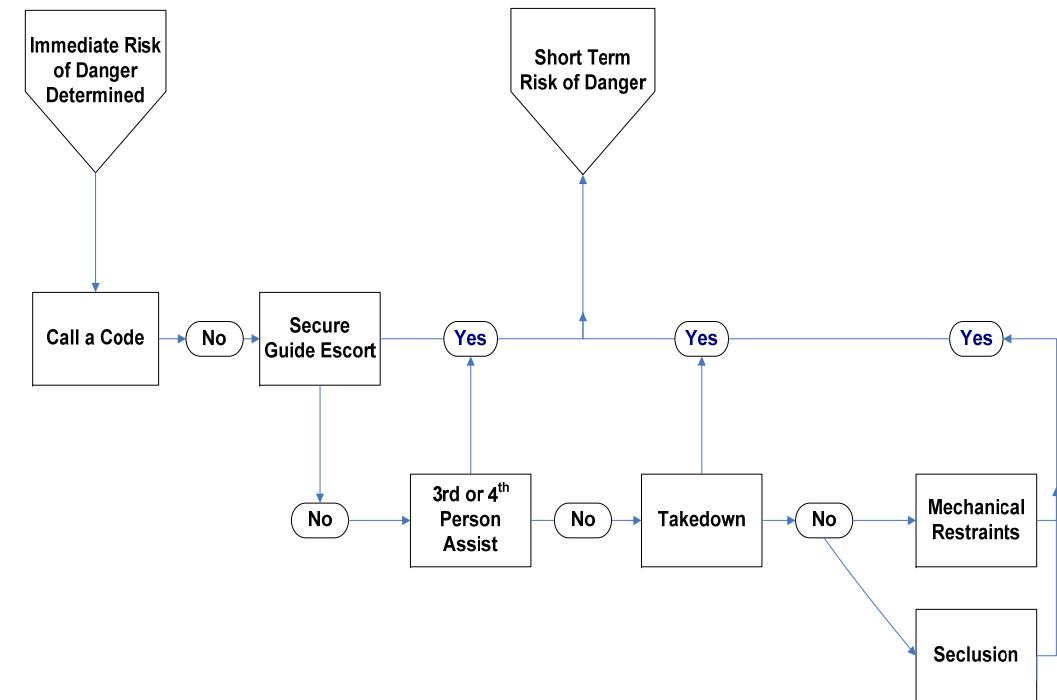
Learning Objectives

After completing this class, you will be able to:

1. Create and maintain safe and therapeutic environments of care that are grounded in understanding the underlying causes of anger and related dangerous and violent behavior :
 - a. Describe the Cycle of Dangerous Behavior and the related Crisis Phases.
 - b. Describe the Four Aspects of Safety.
 - c. Identify your interactional style for use in resolving conflicts and enhancing interactions with patient and co-workers.
2. Use risk management strategies to prevent dangerous behavior from escalating to violence:
 - a. Describe and demonstrate critical thinking and decision making process using the Risk Management Process.
 - b. Define Restraint and Seclusion per DMHAS Commissioners Restraint and Seclusion Policy's 22 A and B.
 - c. Describe the right of employees to work in a safe environment per the DMHAS Commissioner's Policy , Violence in the Workplace Policy Chap.2.23
 - d. Describe the DMHAS philosophy related to preventing and managing dangerous and violent patient behavior.
 - e. Identify patient and direct care staff risk and protective factors for violence.
 - f. Identify typical underlying triggering situations and the underlying causes of dangerous behavior.
 - g. Describe the importance of situational awareness.

Strategies for Escalating and Crisis Situations

This flow chart shows all the possible physically restrictive techniques and decision making points. Yes – means that you are able to contain the behavior and if the immediate risk passes - then you are able to use therapeutic v. restrictive interventions. No – means you are unable to contain or use or this intervention is contraindicated, so you have to move to a more restrictive intervention.



Key
 Yes: Able to Contain
 No: Unable to Contain or Contraindicated

The first action you take in an emergency, is to call a Code. From that point on, the decisions about what restrictive intervention to take depends on your assessment/analysis of your ability to contain the violence using the least restrictive intervention. So, for example, if you determine that you are able to contain using the secure guide escort, then you'd use it. If not, you'd pick the technique that you determine will work. You don't have to try each in the order they are listed- your assessment will determine what technique is most likely to work to contain the violent behavior.

3. Use verbal and non verbal communication with co-workers and patients in non-emergency and emergency situations to reduce the risks to staff, patients and others that are associated with dangerous and violent behavior:
 - a. *Recognize that using Shift Report to plan for non-emergency and emergency situations involving patients with dangerous or violent behavior is critical to reducing the risks.*
 - b. *Identify the key elements of a non-emergency and emergency plan for patients at risk for violent behavior.*
 - c. *Use the 3 W's to communicate.*
 - d. *Use a variety of therapeutic (verbal and non-verbal) interventions to prevent dangerous behavior from escalating to violence (the 3 W's, Conflict Resolution, Verbal De-escalation, Limit Setting; Wait, No and delivering Bad News; other non verbal therapeutic interventions).*
 - e. *Recognize how age, developmental considerations, gender issues, ethnicity and history of trauma may affect the way a patient reacts to physical contact.*
4. Use a variety of safety strategies in escalating and crisis situations to reduce the risk of physically, medically and emotionally traumatizing effects resulting from dangerous and violent behavior and the use of R/S:
 - a. *Determine when to use R/S use when all other non-restrictive interventions have failed or the situation requires an immediate response.*
 - b. *Provide intensive care for the patient in R/S.*
 - c. *Participate in providing intensive care with co-workers using staff debriefings and other forms of support after behavior emergency events.*
 - d. *Describe how to assess when patients have met behavioral criteria to discontinue the use of R/S.*
 - e. *Describe the importance of staff debriefings immediately following a behavioral emergency to reduce the risk of/and effects of emotional/psychological trauma.*
 - f. *Describe typical debriefing activities following a behavioral emergency for staff, the involved patient and others who witnessed it and their role in reducing the associated medical, physical and emotional risks.*
 - g. *Identify essential facts that must be documented in the patient's medical record should a behavioral emergency occur requiring restraint or seclusion.*
5. Correctly use all of the CSS physical techniques in emergency situations and should they fail to be executed correctly, take immediate corrective action to reduce the rate and severity of injuries to staff, patients and others.
6. Use mechanical restraints and seclusion per DMHAS Restraint and Seclusion Policy's and manufacturer's instructions to prevent use related physical injury or death.
 - a. *Use the "A-F" risk assessment model when using restraints.*

Upon successful completion of this class, your attendance and completion status will be added to your transcript in the Saba Learning Management System.



**STRATEGIES for
ESCALATING
and
CRISIS SITUATIONS**



THIRD PERSON TRANSITION TAKEDOWN

- Staff in Secure Guide will step forward and away from the patient
- Pivot 180 degrees, facing patient
- Release your inside hand from holding your wrist and use this hand to secure patient's wrist
- Step forward, heel to heel, your heel behind patient's heel
- Place your inside arm, palm open, underneath patient's armpit
- Third person disengages as staff take two steps, kneeling on outside knee as the patient is lowered to the floor



CREATING SAFE and THERAPEUTIC ENVIRONMENTS



FOURTH PERSON TRANSITION TAKEDOWN

- Two additional staff (5 & 6) approach patient from opposite sides, at 45 degree angle
- Staff 5 & 6 will grip patient's arm closest to them, above the wrist and above the elbow
- Upon verbal cue, staff in Secure Guide will move their Inside leg from in front of patient, pivot to the side while maintaining grip of patient's wrist
- Simultaneously, staff in 3rd and 4th positions will disengage and become Safety Spotters
- Staff 5 & 6 will step in, heel to heel, take two steps and kneel on outside knee



FLOOR CONTAINMENT POSITIONING Following a Takedown

- The patient is always **(Face Up) Supine**, the prone (Face Down) is prohibited
- All staff are positioned facing the patient
- Never apply pressure to the chest or joints, pain compliance is prohibited
- Nothing obstructing patient's airway (Use face shield if needed)

Head:

- Place knees on opposite sides of the head
- Overlap open hands and place on patient's forehead



Arms:

- Pt's arms at a 45° angle, palms down
- Hold the patient's upper arm and just above the wrist

Additional Support: Facing staff securing arms, two additional staff can kneel and hold arms above and below the elbow

Ankles & Legs:

- Cross closest leg over furthest leg
- Wrap your arm around & under patient's Ankles
- Place other hand on shins close to your chest and lean back
- Leg staff are on the opposite side, above or below the knees, hand positions same as Ankle staff



OPEN APPROACH TAKEDOWN

- Two staff approach the patient from the front, at a 45 degree angle
- Outside Hand holds the patient's wrist
- Simultaneously step forward and place Inside Foot behind patient's heel, heel to heel
- Inside Arm hooks under patient's armpit
- Take two steps and kneel on inside knee
- Remain hip to hip, feet shoulder width apart



Creating Safe and Therapeutic Environments

The Cycle of Dangerous Behavior represents the behavioral process that typically occurs when needs are unmet and the person gets angry. All dangerous behavior starts with a triggering event.

A **trigger** is something that sets off emotions e.g., anger, fear, panic, that can lead to an action or series of events. The first step to interrupting the cycle is identifying the triggers.

Anger is a normal human emotion that typically prompts people to take action. For many people – they work to resolve the issue that made them angry using healthy conflict resolution skills. Others choose to ignore it and “let it go” depending on how angry they are about the issue, yet hold on to the issue – which often creates more anger over time in similar situations. **Fear** can also trigger a similar response, but when the person strikes out it's usually for self protection.

For both patients and staff, inpatient settings are complex and often high intensity settings where our patients' thinking/thoughts are compromised by their symptoms. Conflicts are an every day occurrence.

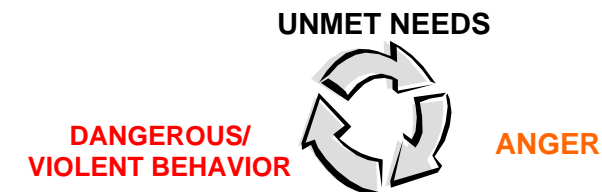
In medical hospitals, most of the time, patients are cooperative with the treatment and accepting of the care provided. In behavioral healthcare, conflicts about care and treatment are more frequent. You, the staff, are often in the position of not meeting needs: saying no, setting limits, etc. or asking people to do things e.g., go to groups – which they may not want to do. These unmet needs, while sometimes intentionally unmet, are at the core of most conflicts – and they often serve as the triggering event – that can escalate to dangerous behavior.

Acting in a caring, compassionate and respectful way – not taking things that patients say personally – can be difficult. The most significant thing that you can do to prevent dangerous behavior is to create an environment that feels safe for both you -the staff - and your patients.

Dr. Sandra Bloom, who created the Sanctuary Model has written extensively on safety in psychiatric treatment settings. She identifies 4 aspects of safety: physical, psychological, social and moral. For more information, visit her website:

<http://www.sanctuaryweb.com/safety.php>

The Sanctuary Model® represents a theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an [organizational culture](#).



Four Aspects of Safety

Physical safety is the easiest to describe – it includes all aspects of the environment that keep you physically safe – i.e., equipment and policy's. Physical safety is a critical aspect of safety - without it, other forms of safety are hard to achieve.

Psychological safety refers to the ability to be safe with oneself, specifically, the ability to self-protect against destructive impulses from within, or from others threat to self (keeping out of harms way). Examples of threats to psychological safety include being talked to sarcastically, lectured at, put down, humiliated, talked to in a negative tone, infantilized, blamed or shamed. Most of us think about this as emotional abuse.

Social safety is the trust that exists in the environment between everyone that is in it. In a safe social setting, people feel cared for, trusted, free to express feelings, unafraid of being abandoned or misjudged. And, they feel connected to each other and not isolated. Rules exist for safety and structure – they make clear what is socially acceptable and what is not and are flexible when safety is not compromised.

In a socially safe setting, there is a high level of awareness about group and individual dynamics. Staff recognizes that behavioral change is hard and works collaboratively with patients to help change behavioral patterns that are destructive. There is a shared willingness and commitment to learning how to get out of tough situations without emotional or physical harm.

Moral Safety encompasses honesty, integrity and doing the right thing. It refers to clear social norms that are not hypocritical. It answers the questions:

- What do we believe in, what are we trying to achieve, will the means get us to the ends and are they justified?
- Do the therapeutic activities we use lead to autonomy, connectedness, empowerment, or dependence, alienation and helplessness?

The Golden Rule is an ethical principle that best describes moral safety as it pertains to caring for and treating people with behavioral disorders: **Treat others as you would like to be treated.** This principle also applies to your interactions with each other. If your relationships with your peers/colleagues doesn't feel safe in all the aspects that we reviewed, your behavior will reflect it and likewise, if your Unit is a safe place– your behavior will reflect it.

In behavioral health, medications and other therapies are very important elements, but the vast majority of work that you do is to help people change their behavior (since the symptoms of MI/SA are mostly behavioral). And this occurs in the context of the relationships you have with your patients where your **use of self is the TOOL** to their recovery.



SECURE GUIDE ESCORT

- Your outside hand holds slightly above the patient's wrist
- Place your inside arm underneath patient's armpit and grab your other wrist
- Extend patient's arm across your body
- Palm facing you, trapped to your hip



Alternate Secure Guide

- From Secure Guide Escort, reposition inside hand to secure the upper arm
- Bend knees, widen/lengthen stance



Fourth Person Assist

- From the Third Person Assist
- Staff in the Secure Guide Escort place their inside leg across and in front of the patient's leg
- Staff in the Third Person shifts over, Fourth Person slides in
- Fourth Person and Third Person help secure the patient, they are in a side stance, back to back



Third Person Assist

- From the Secure Guide, third staff member approaches patient from behind
- Place one hand on patient's shoulder, other hand secures the waistband

Optional: Both hands secure waistband

This year we are teaching you a streamlined version of **WHAT** you need to assess. It's an A-F assessment that includes medical and physical risk factors and emotionally traumatizing effects that can compromise the patients safety. The A-E model was developed by L. Hollins, the F was added by DSS/SETU. Think CPR and the ABC's and think of this as the restraint ABC's. This assessment is a head to toe assessment. Starting at the head/neck...you will check the airway and proceed anatomically down the body:

- Airway**
 - Can they get air in?
 - Is there any pressure to their neck?
 - Is there or other item blocking their airway
 - Is their mouth or throat free from vomit?
 - Are there any signs of airway obstruction? i.e., gurgling/gasping sounds; verbal complaints or difficulty speaking
- Breathing**
 - Are they able to breathe?
 - Is their chest free to move?
 - Is their abdomen free from pressure?
 - Are there signs they are having difficulty breathing? i.e., an increased effort to struggle or heightened distress/anxiety (Excited Delirium)
- Circulation**
 - Can blood be circulated efficiently?
 - Are their limbs free from pressure
 - Are there any signs of tissue hypoxia? i.e., pale/grey/blue skin coloring to the lips, nail beds or earlobes
 - Are there reported symptoms of compartment syndrome? i.e., pain, pins and needles, pulselessness and/or paralysis
- Deformity?**
 - Is there a risk of injury to any joints, limbs, or other skeletal/muscular structures?
 - Is the spine in correct alignment?
 - Are the joints of the upper and lower limbs free from end-of-range stress?
 - Is the patient complaining of discomfort or pain to any party of their body?
 - In addition to the risk of respiratory and cardiac risk factors, remember, that the elderly pose risks associated with poor skin integrity and that their bones tend to be weaker / brittle, so there is a greater risk for injury.
- Existing medical condition or injury?**
 - Is there anything known about this patients medical history that influences risk?
 - Any known respiratory disease?
 - Any known cardiac or vascular disease?
 - Any other relevant pathology or injury?
- Fear**
 - Regardless of the type of restraint or seclusion you use, fear can be a major factor. It may be related to past trauma or the current situation. Despite the fact that you've determined that the use of R/S are justified, your assessment should include any signs of emotional distress. Specifically, listen and look for signs of fear, emotional detachment, tearfulness, or any other emotion related to your use of R/S. This is especially important in determining which intervention to use: restraints or seclusion.

25



PROTECTIVE PHYSICAL SKILLS

- The **person's relationship with potential members**. *Be sensitive to known transference or counter-transference issues when selecting team members, especially in roles where they would be in view of the patient.*
- **Ethnicity**. *If a patient has identified a preference for speaking with someone in their native language all efforts should be made to accommodate that. If there is a known trigger related to an ethnic sensitivity, staff should make every effort to reduce the presence of that trigger during the crisis intervention. Cultural differences are unique to each individual. Staff should explore any observed or noted ethnic preferences and incorporate them into the person's treatment plan.*

In a suddenly erupting crisis, you may not have time or the resources to select the best staff for the best roles. Remember, you can change assignments when it is safe to do so.

The Team Member Role/Responsibilities

Once selected and assigned as a Team Member, always:

- Follow the Team Leader's instructions.
- Tell the Team Leader and Team Members if you voluntarily completed or are about to complete Team Leader tasks e.g., called the MD.
- Monitor the individual's physical status.
- Tell the Team Leader if you are unable to continue in the intervention - that you need someone to take over.
- Use CSS techniques.
- Manage your anger and fear.
- Wait for cue or directions from the leader.

Preventing Restraint Related Injury and Death

The 5 step process for **WHEN** to assess when using restrictive interventions:

Step 1: Done on admission and findings included in treatment plan with plan for reducing risks

Step 2: Done immediately prior to use to determine whether R/S use is safe.

Step 3: Done during application to determine whether to modify your intervention or whether it's safe to proceed.

Step 4: Done during use to determine whether it's safe to proceed as well as when it's safe to discontinue.

Step 5: Done immediately prior to release to ensure that it's in fact safe to do so and to determine if any specific monitoring should occur following discontinuation (in addition to the standard monitoring).

The Team Leader is responsible for determining the plan and directing the interventions. Tasks include:

1. **Identifying self** as the Team Leader and communicating it verbally. If you are called to a crisis and can not determine who the leader is – ask.
2. **Assigning someone to call a code**
3. **Assigning limbs** (arms-arms-ankle-leg-head, if needed extra arms-arms). Be prepared to provide to verbal countdown (1-2, technique and go) when directing a physical intervention.
4. **Assigning someone to secure the scene by** removing other patients from the immediate area and removing items that present a risk.
5. **Assigning someone to the door** of the unit to inform code responders of the situation and instruct them as needed
6. **Assigning someone to get the MD**
7. **Assigning someone to get the restraints & bed/stretchers or prepare the seclusion room**
8. **Manage the emergency through to the end, including organizing the post-crisis staff**

If you decide to turn over the Team Leader role, verbalize it clearly and formally so that everyone knows it changed. Communicate what's happened to the point of handoff.

Typically, there should be at least five members for the takedown. As the team leader you may have to physically participate as needed, while directing the interventions.

Selecting Team Members. When selecting team members, consider assigning staff that are the most appropriate and for what role for the safest possible outcome. Make assignments based on their strengths/abilities as related to the specific patient and the role assigned to them as well as patient related factors including:

- **Trauma issues.** Consider the individual's response to gender of team members (especially in situations where there is a history of sexual assault). When possible have both men and women as part of the team. Give consideration to the placement of team members during the physical intervention.
- The **age and/or physical condition** of the patient. Give special consideration to the elderly as well as those with medical complications. Evaluate the person's strength and physical abilities i.e., some people have skills to defend themselves if they feel threatened.
- **Developmental or cognitive disabilities** should also be evaluated. People with Traumatic Brain Injuries (TBI) or Acquired Brain Injuries (ABI) and individual's in the Young Adult Services (YAS) program should be evaluated for reactions to touch and the need for space. These individual's often feel threatened and have a need for greater personal space and are sensitive to being touched.

Protective Physical Techniques

NOTE: A complete Manual of CSS Physical Techniques is available online and can be found by accessing the DMHAS, Division of Safety Services, Safety Education and Training website.

Personal Space

Ready Stance

Step Slide

Pivot and Parry

Blocks (Inner, Outer, Lower, Leg)

Wrist Releases

Choke Escapes (2 hand Front & Back and Rear arm)

Bear Hug, Hair Pull and Bite Escapes as requested

READY STANCE



- Turn to the side (45 degree angle)
- Feet shoulder width apart
- Knees slightly bent
- Hands above waist level

PROTECTIVE POSTURE



- Assume Ready Stance position
- Forearms upright, in front of upper body
- Elbows are about 90 degree angle, and close to your body

BLOCKS - Upper



- Extend your forearm above and out from the front of your head

BLOCKS - Inner



- Bring forearm across the front of your chest, slightly past your centerline

BLOCKS - Outer



- Extend your forearm away from your centerline

BLOCKS - Lower



- Bring your forearm down across your centerline

BLOCKS - Leg



- Lift the heel of your front foot
- Pivot and turn your body to the side
- Absorb impact on the back or outside part of the thigh

Physical Containment Techniques

- TEAM Roles and Responsibilities
- Preventing Injuries and Death A- E assessment
- Escorts; Guide, Secure Guide (SGE) and Alternate SGE
- Physical Altercation Separation
- Third and **NEW** Fourth Person Assist
- SGE to Takedown
- Open Approach to Takedown
- **NEW** Modified Approach and Takedown

Restraint Use

There may be times when non-restrictive interventions have failed or are contraindicated, and there is immediate risk of harm to the patient or others.

Use only CSS authorized techniques and remember, pain compliance is prohibited.

Seclusion Use

Seclusion may be an option if it is preferred by the person and is safe. Individuals should not be in seclusion, for example, if they are actively suicidal or self-injurious, are unable to contain their outward physical dangerous behavior (physically unsafe), need to be closely medically monitored (medically safe) or traumatized (psychologically safe) by being alone in the seclusion room. Once you've determined that seclusion use is safe, reassess their physical status before leaving them alone and then continue to monitor them closely.

Managing a Crisis using the Team Approach

The Team Leader Role and Responsibilities

The Team Leader can be the staff member that is:

- *Most directly involved in the trigger or escalating phases*
- *Most familiar to the individual*
- *Self-appointed: volunteers to lead*
- *Pre-determined – per policy, or based on earlier Risk Assessment that determined an individual is a Short Term Risk for dangerous/violent behavior.*

Two Handed FRONT CHOKE



- Tuck chin and raise both arms
- Place one foot back
- Pivot your body towards your back foot

Two Handed REAR CHOKE



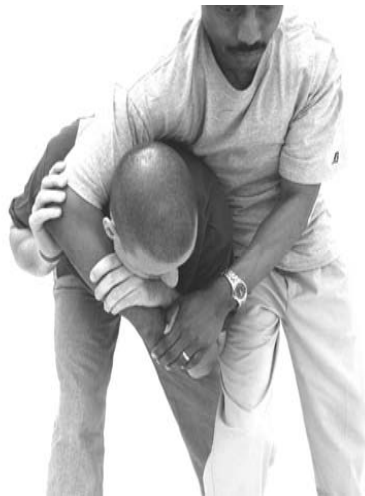
- Tuck chin and raise both arms
- Place one foot forward
- Pivot your body towards your back foot

Rear Arm CHOKE



- Tuck your chin, pull down on arm & forearm,
- Widen your stance & lower your hips, turn your face away from the Pt's elbow

- Pivot your hips and turn your upper body towards the Patient, then place your foot behind the Pt's foot



- Release the grip on the wrist then,
- Place your inside hand on top of Pt's wrist



- As you push forward on elbow—push down on the wrist; slide your head out



MANAGING A CRISIS Involving the use of Restraints or Seclusion

2. How soon after hearing this is it likely to occur (immediate or short term risk)?
3. How severe will the outcome be if it does occur?
4. What do we need to do to reduce the risks starting NOW?

Just because it's a minor request doesn't mean that it's not a big deal to the person. To interrupt the cycle when you think the person might be triggered by hearing no, wait or bad news, plan ahead and consider these things:

WHY: Sometimes, these responses are related to staff convenience rather than how these responses should have therapeutic value (not necessarily mutually exclusive) – so think about WHY you are saying no, wait or giving bad news and if it could be a “yes”.



WHEN: Timing can be everything – consider time of day, weekday vs. weekend or Holiday and your availability e.g., don't “drop the bomb” at end of shift or prior to your being unavailable if you are the primary clinician.

WHERE: Public vs. private space depending on anticipated reaction. Always make sure co-workers know where you are.

WHO: The greater the response or impact, the more familiar and trusting the person should be that's saying no- BUT, sometimes it's better for a neutral person to give the news.

HOW: Choose your words carefully – so that they lessen the potential impact.

Remember, you are creating a situation in all of these, so situational awareness is critical. Whatever verbal technique you decide to use:

Avoid power struggles. Always consider how you request or respond to a patient – remember that it is not about power and control, rather every interaction you have has therapeutic value.

Consider focusing on the positive versus the negative. For example if you want someone to stop doing something, consider phrasing it with what you *want them to do* rather than what you don't want them to do.

Always talk to people in a calm, respectful, compassionate and caring tone of voice. Remember the Golden Rule, treat people the way you want to be treated.

Other Therapeutic Interventions

Distraction There are situations and patients for whom verbal interventions don't work and/ or are contraindicated,. Generally, people who are profoundly impaired by psychosis, delirium or cognitive deficits – may not respond or benefit from verbal interventions. In fact, **less interpersonal stimulation, not more**, may help. Consider other interventions e.g.,

Comfort Room

Sensory Modulation devices e.g., Weighted Blanket

PRN Medications: Used to treat the underlying symptoms of specific diagnoses

Personal Preferences



RISK MANAGEMENT

Staff and Patient Communication

Conflict Resolution Process, NEAR

N = Neutralize... *Be Neutral...It is a method to intervene without escalating the situation by your approach; introduce yourself, give person space*

E = Empathize... *Try to see the Person's Perspective*
Validate person's feelings

A = Actively Listen
Identify the Issue
Ask Open-Ended Questions i.e., Can you tell me what is upsetting you right now? Is there one thing that would be good to have changed (different)?

R = Resolve
Look for Alternatives WITH the person; ask them first
Empower the individual to choose

Limit Setting. The 3 step process for setting limits includes:

1. *Pointing out the maladaptive BEHAVIOR*
2. *Explaining the limit*
3. *Explaining the consequences (without being threatening) and remember, if you think stating the consequences will be a trigger, don't say it.*

Limit setting is used to obtain a desired outcome that is pre-determined by the staff.

Verbal de-escalation. Methods used in verbal de-escalation include:

Verbal overdosing – keep saying “yes”; offer no more than two options – based on personal preferences of the person; reduce arousal – deep breaths, reduce stimulus –move the person or move others – turn off music /TV.

Verbal de-escalation works best for people who are highly aroused-emotional and the goal is to assist the person in reducing the overall level of arousal.

Saying No or “Wait” (can't do it now) and **sharing bad news** (loss of status/level, family emergency, etc) often serve as triggering events and can happen pretty routinely with your patients. They may be asking to go out for a walk and you can't take them right now...or you might be the person telling them that they are not getting a level/status change.

If you don't already do this, ALWAYS consider ahead of time what the response/impact will be and if it will be a triggering event. Consider:

1. How likely is it that no, wait or sharing bad news will be a trigger?
 - How important is it to the person?
 - Have they asked repeatedly?
 - Are they expecting a yes?
 - Are they expecting bad news?

For those patients who are at risk of becoming aggressive or assaultive you should minimally:

- **Identify** who they are and what the potential triggers are – consider flagging charts, notifying the treatment team.
- Determine the acuity (immediate, short, long term risk)
- Have a **Plan** for reducing the risk AND an emergency contingency plan, for those immediate crisis situations.

The non-emergency plan should minimally include the interventions that will minimize triggers and support the patient's ability to self control unsafe or dangerous behavior while ensuring the highest level of safety:

- Interactions: Staff, other patients, visitors (including phone calls)
- Activity: Less or more stimulation (group participation, activities, etc)
- Less or more structure
- Medications: Reassessed and modified as needed
- Freedom of movement: Determining where the person can be (level system)
- Other?

The emergency plan should minimally include:

- Identifying the primary person who will work most closely with the patient to prevent an emergency
- Should an emergency occur, identifying the team leader and members and pre-assigning tasks/responsibilities.
- Notifying the shift supervisor and any others per facility policy, of the potential for an emergency and the plan.

Planning ahead reduces the risks that you or others will get hurt because everyone knows the plan and have a role and responsibility in making sure it's acted on. Teamwork at every phase of treatment is what helps keep you and everyone involved safer.

An easy, simple, direct & focused way to communicate is by using the **3 W's**

What I see – Share clinical information that you see e.g., *I just noticed that Bill is pacing more, is talking more to self -looks angry and preoccupied.*

What I am concerned about – *I'm concerned that this can escalate quickly because he has been refusing his meds and has a history of violence.*

What I Want/Need – *I believe he needs to be evaluated. I don't think he should be alone, I can stay with him until you come.*

The 3 W's are also a great way to communicate with the patients you are concerned about. What you change is the last W and the patient is asked: *What can I/we do to HELP?*

This model structures the discussion for you and the patient and is a great way to discuss non-emergency planning with the patients who are a short term risk for dangerous behav-

Risk Management

The way that you manage the risk of dangerous/violent behavior is by continuously assessing, analyzing, then selecting and implementing interventions and evaluating whether or not your interventions were successful in reducing the risk that you identified:

Assess: *this is when you identify the problem and its severity.*

Analyze: *this is when you consider the possible options of interventions to address the problem in the context of the person(s) involved, the environment that you are in, and who is available to help.*

Select: *based on the analysis - select the intervention/s and develop a plan that will best eliminate or minimize the impact of the problem based on your consideration that **the benefits of your selected intervention outweighs the risks**, since there will always be risks.*

Act: *put the plan into action*

Evaluate: *the person's response to the intervention/s.*

In order to manage the risk of dangerous and violent behavior, a number of other elements are needed e.g., Unit Rules, equipment, a Code system; where used - panic buttons or personal alarms, adequate staffing and importantly: Policies/Procedures. These direct what resources are available to reduce the risks as well as what options you have when selecting interventions.

Your facility's Restraint (and Seclusion where applicable) Policies are essential in providing detailed information and directions about their use in emergency situations.

Restraints: Any mechanical device or physical / manual hold, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Seclusion: The involuntary confinement of a patient alone in a room or an area from which he/she is physically prevented from leaving. Generally, seclusion is used when containment of the dangerous behavior is required and the freedom of movement while in the seclusion room is safe.

Remember, all patients have the right to be free from the use of R/S except as an emergency intervention to prevent immediate physical injury. Non-physical and less restrictive interventions are preferred as the first intervention, unless they have been determined to be ineffective or when safety issues require an immediate response.

And, **all employees have the right to work in a safe environment.**

Commissioner's Policy Violence in the Workplace Policy Chap.2.23: STATEMENT OR PURPOSE: The State of Connecticut has adopted through Executive Order No. 16, a statewide zero tolerance policy for workplace violence. The Department of Mental Health and Addiction Services (DMHAS) fully supports this policy and recognizes the right of its employees to work in a safe and secure environment that is characterized by respect and professionalism.

Clinical Risk Assessment and Analysis

Risk Assessment and analysis are key to determining whether potential or actual danger exists. There are many factors that increase and decrease the potential for dangerous behavior. Factors that increase the risk potential for dangerous/violent behavior are called Risk Factors (RF's). Factors that decrease the risk are called Protective Factors (PF's). The patients at risk have more RF's than PF's. The goal of inpatient treatment is to tip the scale so that the Protective Factors outweigh the risk factors.

Dangerous behavior always occurs in context to a situation that is occurring. The triggering event is not always easily seen and is typically a result of an unmet need. It can be as simple as someone wanting to go for a walk who is told no...to someone who wants to be discharged immediately.

The $B = P \times S$ equation is a quick way to focus on the 3 key risk factor categories (Behavior, Person, Situation).

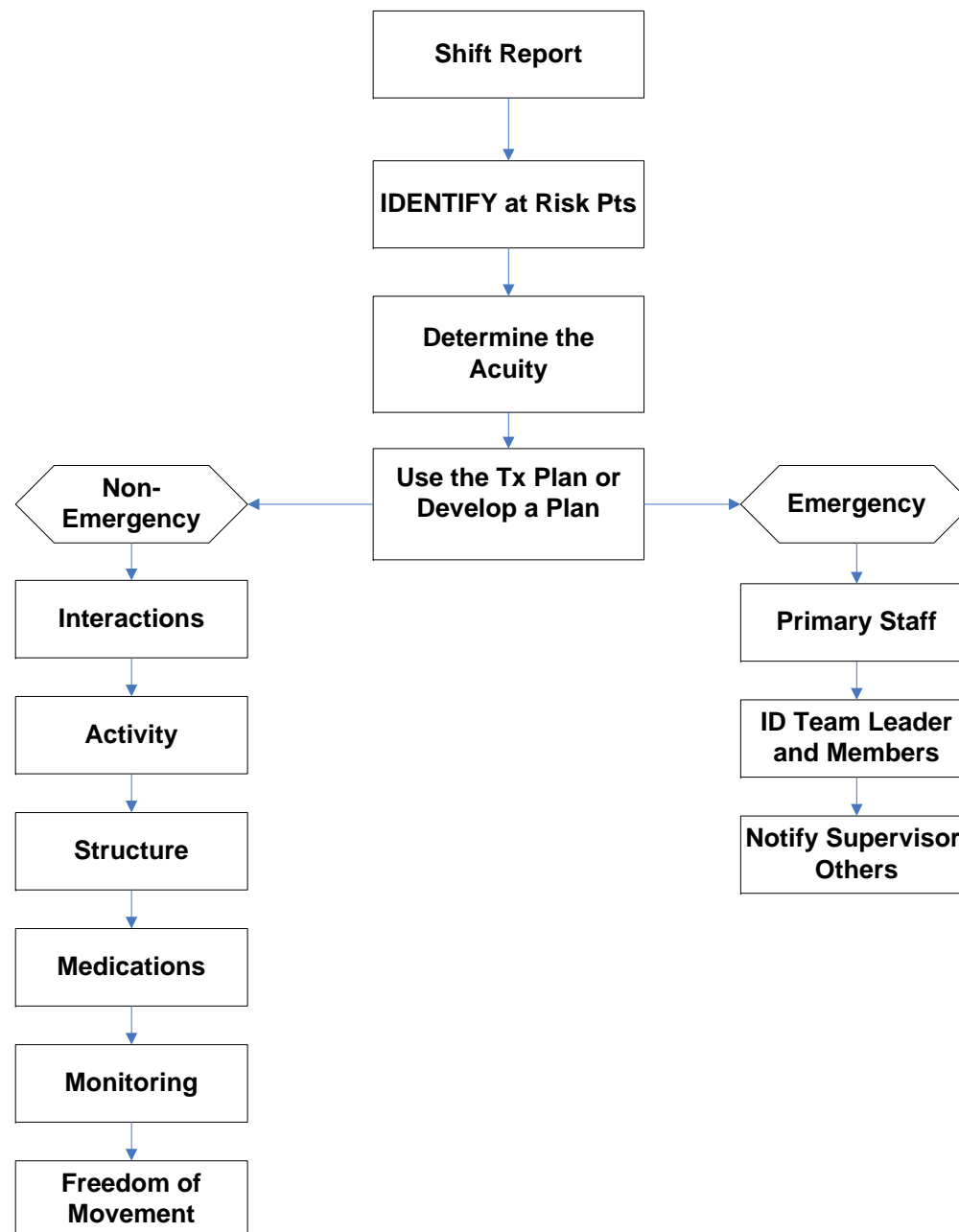
CSS focuses a lot on triggers because triggering events are what put the Cycle of Dangerous Behavior in motion. At the triggering point - you need to take **immediate action** and provide more intensive care. The intensity of care will depend on all the risk and protective factors.

Think about patients who have been triggered and are showing signs of escalating as needing intensive care. Here's the analogy – medically hospitalized patients whose vital signs are dropping dangerously are monitored more closely and medical interventions are implemented immediately to stop the decline. Medical staff don't wait until they are near death and then initiate life saving measures, they work rapidly and aggressively to stabilize the patient at the first signs of danger.

In behavioral healthcare, the signs that people are decompensating are primarily behavioral – we see their behavior change. Typically, when triggered, we see a response that indicates whether or not they are able to self control their behavior. Waiting until the person's behavior has escalated to dangerous levels is too late – you must immediately intervene to provide more intensive care and the assessment will tell you what kind of care to provide.

Patient Risk Factors

- **H/O Violence:** those who have acted in aggressive or violent ways in the past are more likely to be (violent) in the future, unless they've learned and mastered anger management and other coping skills.
- **Untreated or active psychosis**
 - **Paranoid delusions** because they cause a great amount of imagined fear. This is especially true if the delusion includes a belief that one's **thoughts are controlled by external forces**. This belief can lead to dangerous behavior because the person feels that they have no control over their own actions – thus, they are also acting in self-defense.



Strategies for Enhancing Safety and Interrupting the Cycle

Communication Barriers

Interruptions and distractions - which happen frequently.

Attentional Narrowing – which is when your focus gets restricted. Specifically, you focus too much on one piece of information and miss peripheral factors that are equally important. This happens especially under great stress, or when you are deeply involved in managing an emergency situation.

Memory overload – working memory is keeping information in your thoughts so that if you need it, you can use it. Again, there are limits to what you can remember and overload is not uncommon, especially when you consider all the detailed information that you are paying attention to on any given day.

Added to these, other things impact situational awareness like time pressures, fatigue, being floated to another Unit, poor teamwork, poor communication. It's understandable, that paying attention to everything and constantly being aware of each situation can be difficult.

One of the best ways to overcome these limitations is to communicate frequently with those that you are working with about what you are seeing and hearing. This helps keep information flowing and allows everyone to help in putting the pieces of information together. Information sharing plays a significant role in reducing risks – the more you know, the more opportunities you have to interrupt the Cycle.

There are lots of formal and informal communication events that you are involved in such as Treatment Planning Meetings, Shift Change Report and communicating information throughout the shift. Keeping the information flow going – with all the various people and information – can be hard—but is essential to reducing risks.

In terms of planning ahead, **Shift Report** is an excellent opportunity to share information and plan ahead and should be attended by all of the incoming staff. If you do not already structure your shift report in the following way, consider changing it so that it provides the information that you need to maintain safety.

- **Command hallucinations** can lead to dangerous behavior because - up to 40% of the time – patients are likely to obey the command and especially when the hallucination is related to a delusional belief, and when the voice is familiar to the person.
- **Substance Abuse:** those who are actively abusing and or in withdrawal are more likely to become aggressive/violent especially if they are using alcohol, stimulants or other psychoactive drugs.
- **Unseen:** Rather than thinking of violence as unprovoked it is more accurate to say that provocations were unseen or hidden. A person's thoughts and emotions can be antecedents to behaviors. These planned and targeted displays of dangerous behavior are most often – but not exclusively – displayed by person's with anti-social personality disorders, i.e. those who belong in the "won't category" of reasons why people aren't able to self regulate their behaviors.
- **Military experience** – people who were involved in or witnessed direct combat have at the very least, experienced violence in a very different way. And, these experiences may have resulted in PTSD and may be easily triggered by environmental sounds e.g., unexpected loud noises. This coupled with weapons and other fighting training can result in higher levels of violence. At the same time, their military experience related to self control and discipline can be a protective factor.
- **Weapons and/or martial arts training** – risk for planned attack and how to injure is greater when people have been trained, should they attack.

The Three Major RFs: history of violence, untreated or active psychosis and substance abuse.

Environmental/Situational Risk Factors

There are numerous environmental and situational risk factors e.g., lack of privacy, overcrowding and cramped physical space, lighting, temperature and noise, no activity areas; nothing to do.

Patient Protective Factors²

- Religiosity
- Life satisfaction
- Reality testing ability
- Engagement in treatment
- Positive coping skills
- Positive problem solving skills
- Positive social support (family and friends)
- Positive relationship with ones therapist
- ***A trusting relationship with a person (THE most important)***

Staff Risk and Protective Factors

There are numerous staff risk factors e.g., unmanaged fear, youth & inexperience, fatigue, giving bad news, speaking disrespectful, lack of training.

There are numerous staff protective factors e.g., experience, training, managed fear, all the aspects of a safe and therapeutic environment and the opposite of the risks (e.g. fatigued/rested/supported, poor - good overall approach and demeanor).

Triggers

Typical situations that trigger anger include:

- Hearing bad news (e.g., laid off, divorce, loss of Level, being told no)
- Lack of Privacy
- Being stared at, touched, isolated
- Being teased, shamed, humiliated
- Particular time of day, night or year
- Contact with people e.g., family, friend...staff with whom they have issues.
- Access to his/her money
- Access to own bedroom
- Smoking ban
- Patient contraband and bartering
- Required attendance at programs/activities
- Medication administration time
- Access to telephones

² www.clevelandclinicmeded.com; Psychiatric Emergencies, George E. Tesar Published 8/1/10

Typical feelings that trigger anger include feeling:

- Betrayed
- Treated unfairly
- Threatened
- Disrespected
- Wrongly Accused

Remember, how you talk to your co-workers and patients sets the stage for a safe environment. Your behavior, words and actions can trigger a patient or escalate a situation.

And, sometimes the thought of an unresolved situation can trigger anger or just being in a situation that triggered anger in the past can trigger anger in the present. Importantly, if you have unresolved conflicts with your patients - that may be a result of transference or counter transference, you need to address it to avoid inadvertently triggering them.



STRATEGIES for ENHANCING SAFETY and INTERRUPTING the CYCLE

Remember, things that trigger anger can be real or perceived. It's not uncommon for people with chronic and persistent symptoms of mental illness, neurological deficits; or people who experienced trauma, or who are abusing substances to misperceive situations or what is said. For example, people who:

- Are experiencing voices or delusions can misperceive reality.
- Have brain injuries, mental retardation or other cognitive deficits can misperceive/misunderstand as a result of these deficits.
- Have been abused typically have difficulty with anger – both expressing it and responding to it. While the majority of our patients have experienced trauma, our young adults with personality, behavioral and developmental disorders are at greatest risk for being easily triggered as are those with PTSD. People with PTSD can be triggered by flashbacks.
- Are intoxicated; in withdrawal or have long abused substances.
- Are extremely medically ill or are having an adverse medication reaction are also more vulnerable to being easily triggered.

Sometimes, you might trigger a person by not respecting cultural norms. There are many cultural norms for human behavior. Most of the information on cultural differences is generalized, and it's dangerous to generalize because so much of how we behave is influenced by more than just our culture. So, these are just general bits of information about eye contact, speaking volume and touch. As always, learn what triggers your individual patients.

Eye Contact. The duration and frequency of eye contact communicates a great deal—honesty, respect, shame, interest—but the norms can differ widely among cultures.

- African-Americans use more eye contact when talking and less when listening with reverse true for Anglo Americans.
- Among Latinos, it is respectful to avoid direct eye contact with authority figures.
- Among Asians, direct eye contact is very brief, with the gaze then sliding away to the side, especially with superiors or opposite sex.

Speaking Volume. White Americans typically interpret raised voices as a sign of anger or hostility. Among non-white Americans and other ethnic groups e.g., Latin Americans, Africans: it may simply signify an exciting conversation.

Touch. Compared to other cultures, Americans rarely touch each other, limiting ourselves to handshakes and occasional pats on the shoulder or arm in business relationships, or hugs in closer friendships.

- Latin Americans and Middle Easterners touch with much greater frequency. In these cultures, it is not uncommon for two men to hold hands, signifying nothing more than friendship.
- Japanese touch less than Americans and may be uncomfortable being touched in a casual relationship. Touching someone on the head is offensive to most Asians.
- People from cultures with conservative customs regulating inter-gender relationships may be extremely uncomfortable being touched by someone of the opposite sex. Diversity Tip Sheet, The Diversity Council – DMHAS 2008

Other factors that can affect how people respond to their angry feelings include (but aren't limited to):

- Poor impulse control
- Poor coping skills or ability to self manage angry behavior
- Don't care and/or anger is used as part of intimidation.
- Fatigue
- Being overstimulated/overactivity

Once you've identified the triggers, the next step to interrupting the Cycle is to identify the person specific risk factors and what types of situations might trigger him/her. The treatment plan should identify potential triggers and specific interventions to avoid those situations, or to reduce the potential response to them. Many of these triggering situations are related to your role in setting limits related to Unit Rules making you, the staff, the person who provides the trigger. So, when possible, create specific interventions that address what you'll do related to Rules.

Warning Signs

Once you've identified the triggers, the next step to interrupting the cycle is to identify the early warning signs. Each person has their own unique warning signs – learn what they are and include them in your treatment plan. Some typical warning signs include:

- Restlessness, pacing, agitation
- Or other obvious signs of anger such as clenched teeth, breathing hard, loud voice, etc.
- Or, the person can become silent, withdrawn, staring into space
- Increased diagnostic symptoms, e.g. – more psychotic, depressed, manic, etc.

Rarely, but sometimes, the early warning signs aren't readily observable. Sometimes, just a thought can trigger a person. That's why it's important to talk to your patients regularly about what they are thinking and feeling and to pay attention to any change in the patient's behavior – even becoming withdrawn, silent.

Assessing and Determining the Level of Risk

When you are determining the level of risk of danger, you are considering **HOW SERIOUS** you think the risk is and **WHEN** you think the dangerous behavior might occur. To best determine this, you have to pay close attention to the situational context. This is called situational awareness. It's the ability to understand what is occurring in the immediate environment and give meaning to what is happening to form a clinical picture, and importantly – to determine what will happen in the immediate or near future. It is the assessment/analysis (B=P X S) process in action.

Here's what happens when you break it down:

First, you may hear or see behavior that catches your attention. Then, you attach meaning to it based on the person risk factors and you then you put the information (what you heard, saw, who's involved, etc) together in the context of the situation and determine what you think may or may not happen in the immediate or near future – that's your analysis.

What's critical about this thought process is that it happens very quickly. If you miss any of the important pieces of information, your decisions and actions will be made based on missed information and will have a direct impact on what actually happens.

A serious risk of aggressive or violent behavior exists when the patient and staff risk factors outweigh the protective factors –

B = P X S. Behavioral signs will be obvious and the situation will most likely be similar to past situations when the person become violent.

In CSS, we've focused on the immediate risk – this year we also want you to consider short and long term risk:

Immediate – is about to happen or is happening right now.

Short Term – high likelihood within 24 hours on an Inpatient Unit.

Long Term – means that it can happen in the future. People with a long term risk may become aggressive in a specific situation – e.g., an anniversary date...or a court hearing. And this is especially true if they are relapsing or under significant stress e.g., about to be discharged.

Thinking about *when* dangerous or violent behavior might occur is important because it helps you think and plan ahead. Think not only about specific patients, but consider all the patients who are at risk in context. Specifically, you should be determining out of your total inpatient census:

Who's at risk - e.g., out of 15 patients, we have 5 who are at risk for dangerous behavior.

Then break it down further, e.g. out of the 5, 2 are at short term risk and 3 are a long term risk. This break down helps you focus your planning.

Think about it this way: of the at risk patients that you identify, your approach should be that it's not a matter of IF they will be dangerous or violent, but **WHEN**. And, remember OSHA's Universal Precautions for Violence:

Violence should be expected but can be avoided or mitigated through preparation.

