Collaborative Safety Strategies

Annual Outpatient Review Training Program

Participant Handbook

dmhas

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 Outpatient 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/medical pubs/diseasemanagement/psychiatry-psychology

5. McPhaul K, Lipscomb J, Johnson J: Assessing Risk for Violence on Home Health Visits. Home Healthcare Nurse Vol.28-Issue 5, p. 278-289, May 2010.

6. NIOSH Hazard Review: Occupational Hazards in Home Healthcare. Whitepaper from Department of Health and Human Services, CDC, National Institute for Occu pational Safety and Health.

Strategies for Enhancing Safety in the Outpatient Community Setting

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

2. US Postal Service (Dog Attack Prevention)

3. American Veterinary Medicine Association. **Avma.org** (Dog Attack Prevention)

Safety Strategies for Escalating and Crisis Situations

1. DAS Workplace Violence Train the Trainer Program (Extreme Situations)

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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.

In the event that the crisis occurred in your facility setting, the staff minimally should debrief shortly after the event to discuss what worked and didn't.

In the event that it is a residential setting, or setting where other clients were present when the crisis occurred and/or witnessed it; a <u>Debriefing</u> and should occur immediately follow-ing the crisis.

If a crisis occurred in the community, depending on your facility policy, more likely, the inci-dent will be debriefed in your team meetings and with the client when it is appropriate and possible (i.e., if pt actively psychotic and hospitalized, it will have to wait until the client is able to participate).

The debriefing may result in a modification of the Treatment Plan, or may alter work prac-tices to reduce the risk of reoccurrence.

Documentation

The documentation of any behavioral crisis in the client's medical record must be detailed and specific. It should include:

- What occurred prior to the event: behavior, situation, etc.
- What interventions were used to try and prevent the behavior from escalating and what the client's response was.
- If a safety intervention occurred, list the specific physical techniques that you used. Include your medical/physical assessment findings.
- If the client was hospitalized, or returned home – where and what clinical factors were present that made that decision occur.
- The next step in the plan.

Documentation forms are specific to each facility so follow the guidelines for documenta-tion at your facility.

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

Debriefing

Being involved, either directly or by a behavioral emergency 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 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; and
- 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 a crisis occurs.

Always debrief with the client immediately after the emergency (or as soon as possible). The Team Leader is responsible for making sure that a staff debriefing occurs immediately after in 24 hour settings 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 Treatment/Recovery plan.

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

OVERVIEW

Extreme Situations: Hostage

If you see/hear a hostage situation taking place:

- Escape from immediate danger if you are able to.
- Call 911 or your facility emergency number – whichever applies
- Provide as much information as you can e.g., location, physical description, names, weapons, number of people taken hostage, etc.

If you and/or others have been taken hostage:

- Remain calm, polite and cooperative.
- Don't draw attention to yourself with sudden movements, comments or hostile looks.
- Be patient, time is on your side. Avoid drastic action.
- The first 45 minutes are the most dangerous.
- Stay alert and observant.
- Look for escape routes and places to take cover, create distance and barriers. Try to stay low to the ground, away from windows or doors.
- Do not try to escape unless there is an extremely good chance for survival.
- Take note of the captor(s) appearance: clothing/shoes, person's size, physical traits including tattoos, scars, voice quality-patterns, etc. This information will be important in providing a description later. If possible, keep your eyes on the hostage taker and note what they are doing at all times.
- Don't speak unless you are spoken to and then only when necessary.
- Avoid talking about politics, ideological topics or religion. Do talk about yourself, your life, family-try to establish a positive relationship with the captor.
- If you are forced to present any demands to the authorities, on tape or in writing – state clearly that the demands are the captor(s). Avoid making pleas on your behalf.

Upon rescue:

- DON'T RUN. Stay on the floor, or drop to the floor, or stay standing still with your head bowed down, hands out and visible. Don't make any sudden movements.
- DON'T argue or resist, even if you are handcuffed or searched.
  The rescuer may not be sure who the hostage(s) or captor are. You will be taken to a safe area where your identification can be determined.

www.emergency info.txstate.edu/emergensituations/armedind/hostage.html

Emergency Preparedness, Hostage Situation Southern CT State University

www.livesecure.org/how-to-survive-a-hostage-situation/ Article by Clint Van Zant, former FBI Hostage Negotiator and Army Intelligence Agent

Extreme Situations: Threats with Weapon

If you are being threatened with a weapon always:

- Stay calm and breathe. Manage your fear.
- Use your best judgment about the right thing to do in view of the specific circumstances of the event.

If Escape is Possible, DO:

- Signal for help
- Seek cover behind or under objects or just lie on the floor where you are. Try to keep out of the perpetrator's sight
- Be aware of all floor and possible window exits. Never use an elevator unless directed to do so.
- Maintain eye contact with the perpetrator-watch eyes and hands.
- Mentally locate objects to use for defense

DON'T

- Move or make sudden gestures that might alarm or attract the attention of the perpetrator
- Block or corner the perpetrator.
- Argue with the perpetrator. Follow instructions and do what the person tells you.
- Turn your back to the person
- Risk harm to yourself or others – do not try to be a hero by grabbing the weapon

If you must Converse with the person, DO:

- Stall for time. Engage the person and try to keep them talking
- Keep your palms up and open – ready stance
- Keep a barrier between you or the object or safe personal space
- Talk in a calm tone of voice
- Use direct, concise statements
- Actively listen, restate and paraphrase as possible
- Personalize the conversation – talk about yourself, family, etc.
- Address the person by name if you know it
- Negotiate – ask for permission
- Assess possible options and offer them (you can put that down now)

DON'T:

- Make quick or jerky movements
- Argue, challenge or contradict the perpetrator

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.

The US Dept. of Labor, reported in its News Release Nov. 9, 2011[1] 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 client related, nor is it separated by setting type, i.e. psychiatry. Still, other literature supports these findings. A survey conducted by the Bureau of Labor Statistics reported in 2006[2] that the rate of nonfatal assaults on home healthcare workers was 5.5 per 10,000 full time workers. This is more than twice the rate for all US workers.

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 client 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 Safety Intervention per DMHAS Commissioner's Policy 22E*
    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 client behavior in the outpatient and community setting*
    e. *Identify Client and Direct Care Staff Risk and Protective Factors for violence.*

[1]US Dept. of Labor, reported in it's News Release Nov. 9, 2011 (USDL-11-1612, page8-9)

[2] NIOSH Hazard Review: Occupational Hazards in Home Healthcare. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health p33.

    a. *Identify typical underlying triggering situations and the underlying causes of dangerous behavior when providing care at DMHAS facilities or in the community setting*
    b. *Describe the concept of Situational Awareness*
    c. *Use critical thinking and decision making skills in emerging dangerous situations*
    d. *Use personal safety risk assessment strategies in the community setting to reduce the risk of victimization.*

3. Use verbal and non verbal communication with co-workers and clients in non-emergency and emergency situations to reduce the risks to staff, clients and others that are associated with dangerous and violent behavior

    a. *Recognize that using Team Meetings or in 24^0 care settings, shift report, to plan for non-emergency and emergency situations involving clients with dangerous or violent behavior is critical to reducing the risks.*
    b. *Identify the key elements of a non-emergency and emergency plan for clients at risk of violent behavior*
    c. *Use the 3 W's to communicate clinical information*
    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, 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 my affect the way a client reacts to physical contact.*

4. Use a variety of safety strategies in escalating and crisis situations to reduce the risk of physical, medical and emotionally traumatizing effects resulting from dangerous and violent client behavior or criminal behavior including extreme situations in both DMHAS facilities and community settings.

    a. *Determine when a Safety Intervention requires an immediate response.*
    b. *Describe basic safety strategies in situations involving a weapon or hostage situation.*
    c. *Describe basic safety strategies for use in community settings when working with clients or when alone.*
    d. *Participate in providing intensive care with co-workers using staff debriefings and other forms of support after behavioral emergency events.*
    e. *Describe how to assess when clients have met behavioral criteria to discontinue the use of a Safety Intervention.*
    f. *Describe what to report to DMHAS or Municipal Police in an emergency situation in the Community Setting while maintaining confidentiality.*
    g. *Describe debriefing activities following a behavioral crisis or criminal victimization.*
    h. *Describe the importance of staff debriefings following a behavioral emergency to reduce the risk and effects of emotional/psychological trauma.*
    i. *Identify essential facts that must be documented in the client'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*)*
    a. *Use the "A-F" risk assessment model when using a safety intervention.*

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Behavioral Emergencies in the DMHAS Facilities

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 the intervention or it is contraindicated.

In an emergency in a DMHAS facility setting, icall 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.

CRMHC, CMHC, GBCMHC and RVS Only

For those of you who work in DMHAS locations that have DMHAS police, call a Code. At RVS, contact MCT first. The role of the DMHAS Police in a Code is only to **assist** you. These are clinical crisis situations, not law enforcement situations. So, they should only assist when you need more help than is already available. Do not automatically assign an officer a physical intervention role, rather use the clinical team.

Should you exhaust your ability, to contain clinically dangerous behavior or if the behavior is of a law enforcement nature, then the team leader can turn over the leadership and management of the crisis to the Police. The team leader should provide the basic information about what has happened and how you want them to help.

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Municipal or State Police

If you are in a court or other state agency- learn who to contact (e.g., Marshall) in an emergency. If you are in a public area or other non-DMHAS setting then you'd call 911. If you are in a facility that has private security, follow your facility policy about who to contact in an emergency. Regardless of who you call for emergency assistance, be prepared to provide the following information:

- Identify yourself and facility you work for
- Give your location and if different from where the client is, the client's location
- Describe the nature of the emergency e.g.,:
     - What the dangerous behavior is and if weapons involved
     - History of dangerous behavior
- Who else is directly at the scene and at risk
- Ask if they have CIT trained officers and suggest that if possible, they respond to the incident.

If you are calling from another location/scene when 911 was notified, you must inform the Police Officer in charge of what has transpired and what assistance you want from them as well as follow your facility policy about who else to notify e.g.,
Crisis Team.

Behavioral Emergencies in the DMHAS Facilities
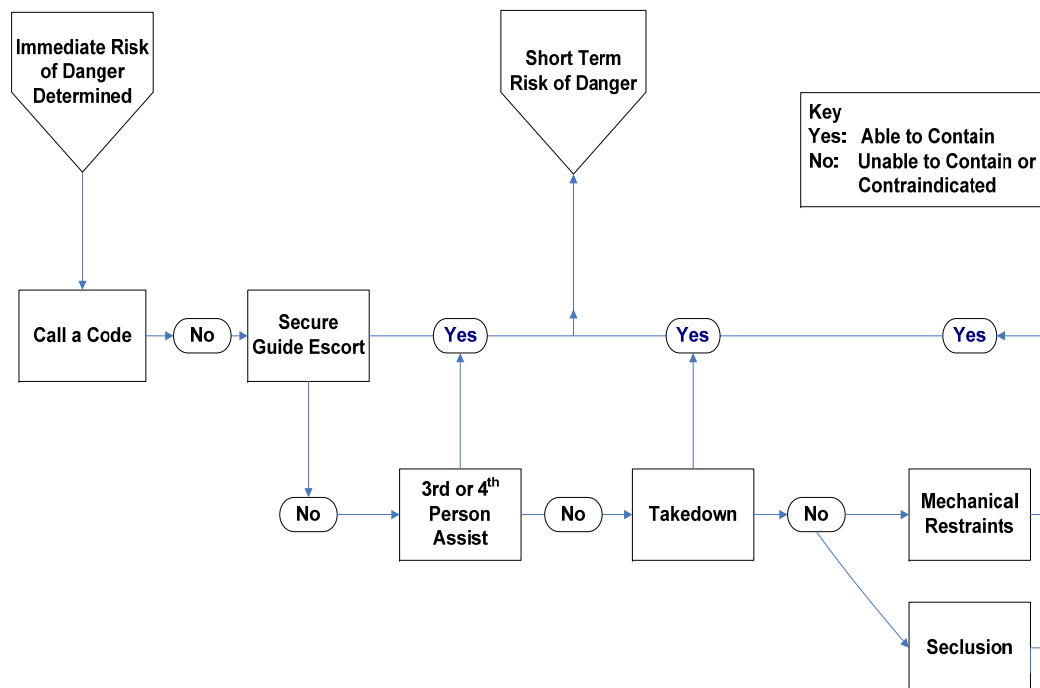
Creating and Maintaining Safety in the Outpatient Setting

Strategies for Escalating and Crisis Situations

Behavioral Emergencies in the Community

I**f you are alone with the client** and there is a threat of danger, leave or escape the situation. Then, follow your facility policy about who to contact.

If you are unable to escape, create barriers between you and the aggressor. If possible, call 911. Try to engage the person and defuse the situation until you can escape - use NEAR. We'll be talking about additional things you can do or say if you are held hostage.

Be willing to be wrong: forget about being right and concentrate on doing what's best in this situation. Doing what's best may be different from doing what you think is right. For example, you are told never to lie to a client. In a dangerous situation, lying may be the best thing to do to create an opportunity to escape.
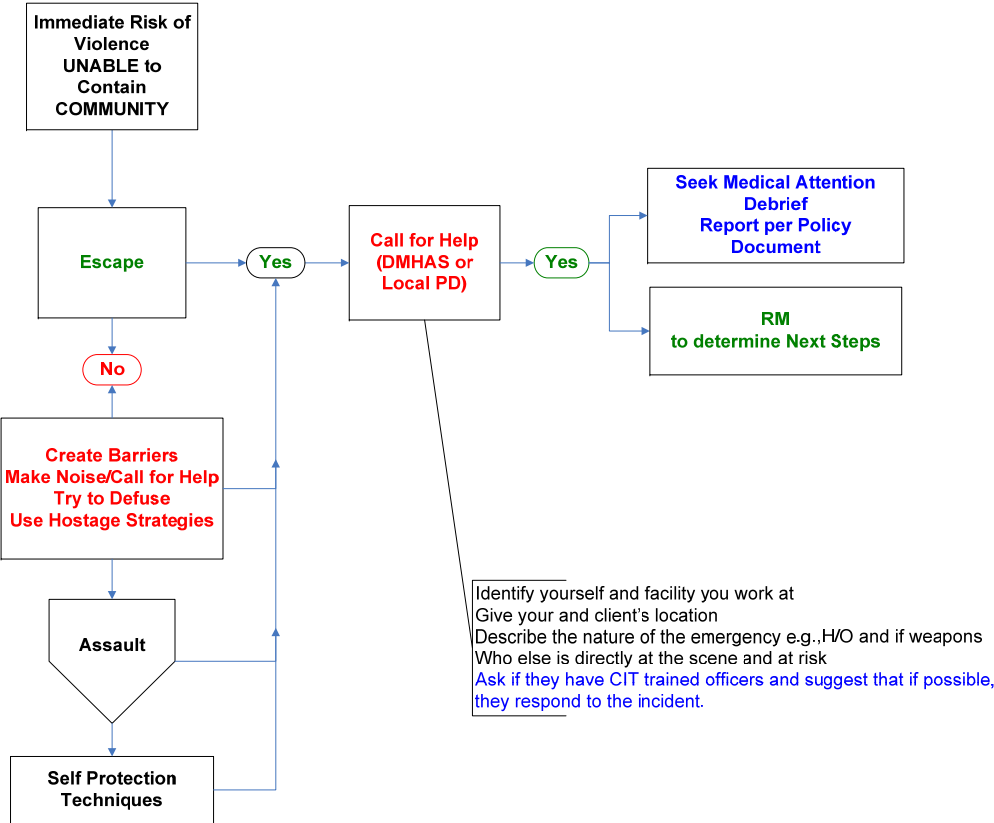
If you are physically attacked – assaulted, use the self protection skills to create an opportunity to escape or protect yourself from further injury. Yell for help, make as much noise as you can. Use your whistle or personal body alarm.

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  │  Self Protection   │
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Identify yourself and facility you work at
Give your and client's location
Describe the nature of the emergency e.g.,H/O and if weapons
Who else is directly at the scene and at risk
Ask if they have CIT trained officers and suggest that if possible, they respond to the incident.

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Creating and Maintaining Safety in the Outpatient Setting

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.

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 danger-ous behavior is to create a relationship that feels safe for both you -the staff - and your clients.

And for those of you who work in 24^0 care settings or programs where clients come for treatment, you are also working to create and maintain safe environments.

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

UNMET NEEDS

**DANGEROUS/
VIOLENT BEHAVIOR**   **ANGER**
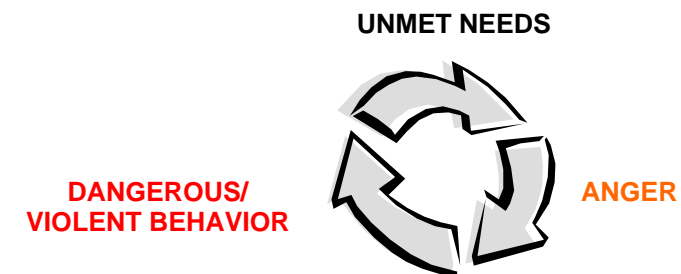
The Sanctuary Model® represents a theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organiza-tional culture.

Four Aspects of Safety

Physical safety is the easiest to describe – it includes all aspects of the environment that keep you physically safe – such as panic buttons, having cell phones, policy's e.g., workplace violence, Safety Interventions.   Physical safety is a critical aspect of safety and without it, other forms of safety are hard to achieve. Because you are often working in environments that are not controlled by your facility, you have to be especially alert to the physical environment and take additional precautions.

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. Our clients that live in the community, who have chronic and persistent mental illness are more likely to be humiliated or shamed by the general public.

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. They should be clear and firm, but flexible when safety is not compromised. We have little control over the living environments – and many inner city, high crime areas are not socially safe. However, social safety is important in our 24^0 care settings or programs where clients come for treatment.

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**.

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). Helping people change occurs in the context of the relationships you have with your patients where your **use of self is the TOOL** to their recovery.

Working with clients, many of whom have difficulty expressing their anger and fear in a socially appropriate way can be difficult.   Each interaction you have –whether it's with other staff members or with a client - is an opportunity to role model healthy adaptive behavior and importantly teach people socially appropriate skills and coping skills. The positive/healthy behaviors that you model provide the best learning opportunities for everyone.

The way you talk to/and treat clients should always support all the aspects of safety. This is critical to your therapeutic relationships and creating - maintaining a therapeutic culture.

STRATEGIES for ESCALATING and CRISIS SITUATIONS

PROTECTIVE PHYSICAL SKILLS

THIRD PERSON TRANSITION TAKEDOWN

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

FOURTH PERSON TRANSITION TAKEDOWN

- Two additional staff (5 & 6) approach client from opposite sides, at 45 degree angle
- Staff 5 & 6 will grip client'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 client, pivot to the side while maintaining grip of client'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 client is always supine (**Face Up**), the prone (Face Down) is prohibited
- All staff are positioned facing the client
- Never apply pressure to the chest or joints, pain compliance is prohibited
- Nothing obstructing client's airway

(Use face

Head:
- Place knees on oppo-site sides of the head
- Overlap open hands and place on client's forehead

Arms:
- Pt's arms at a 45% angle, palms down
- Hold the client'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 client'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 posi-tions same as Ankle staff

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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 Handed Front & Back and Rear arm)

Bear Hug, Hair Pull and Bite Escapes as requested

READY STANCE

PROTECTIVE POSTURE

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

- 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

OPEN APPROACH TAKEDOWN

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

SECURE GUIDE ESCORT

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

Third Person Assist

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

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 client's leg
- Staff in the Third Person shifts over, Fourth Person slides in
- Fourth Person and Third Person help secure the client, they are in a side stance, back to back

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 Arn CHOKE

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

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

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 client 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 technique 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 a Safety Intervention is 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.

Hollins L: Managing the risks of physical intervention: developing a more inclusive approach. Journal of Psychiatric and Mental Health Nursing, 2010 17, 369-376

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).*

RISK MANAGEMENT

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 client and the role assigned to them as well as client 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 client. *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.*

- 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 client.*

- **Ethnicity**. *If a client 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 ethic 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.

Physical Techniques: Crisis

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

Physical Restraint Use

There may be times when non-restrictive interventions have failed or are contraindicated and there is immediate risk of harm to the client or others.
Use only CSS authorized techniques and remember, <u>pain compliance is prohibited</u>.

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.*

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 clients 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/stretcher or prepare the **seclusion room** *where used*
8. **Manage the emergency** *through to the end, including organizing the post-crisis staff debriefing*

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.*

Risk management in the outpatient setting is used in 3 distinct ways to:
1. Prevent and manage dangerous and violent behavior in contained settings e.g. at your facility where clients come for services, or in acute and brief care settings
2. Prevent and respond to dangerous behavior in the community e.g., home visits
3. Prevent your risk of victimization in the community

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Safety Intervention: Any physical (manual) holding or redirecting of the client's body that limits, even if only briefly, the freedom of movement and access to his/her body needed to prevent injury to self/others.

The DMHAS philosophy and Commissioners Policy #22E, on which your local facility policy is based, states that out-patient and community based clients have the right to be free from the use of safety interventions except as an emergency intervention in which there is significant risk of physical injury.

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. 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 clients at risk have more RF's than PF's. These factors are important for determining who is at risk for responding to triggers in an angry and aggressive way. The goal of Out-patient treatment is to keep the scale tipped so that the PF's outweigh the RFs. Dangerous behavior always occurs in context to a situation that is occurring.

The B= P x S equation is a way to quickly 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 Danger-ous Behavior in motion. For those clients who have learned to self control dangerous and violent behavior, this is less of an issue because they have better coping skills - they are in essence self interrupting the cycle of dangerous behavior. These aren't the clients we are focusing on; we're focusing on the clients who are at risk for dangerous or violent behavior.

Because most of you are not monitoring clients around the clock, you may not know that the person was triggered and you could walk into a highly charged situation. Or, you might be in a situation with the client when someone else triggers them – like a friend or family member. Or, you could be the person who triggers them in the course of the services you are providing.

Regardless, when a client who is a risk of becoming dangerous or violent behavior is trig-gered, they must be immediately assessed to determine how to proceed. They may need a higher level of care – more home visits, or they may need to be removed from the trigger-ing environment and go to respite or brief care.

Client 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.

  - **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.

MANAGING A CRISIS

- **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 SA.

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.

Client Protective Factors

- 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 Factors

There are numerous outpatient staff risk factors e.g., unmanaged fear, youth & inexperience, fatigue, giving bad news, speaking disrespectful, lack of training. Many of the risks are a result of providing care in settings that are not controlled by your facility/DMHAS:

- Caring for people who often reside in dangerous communities with high crime rates or in rural areas where you are more isolated,
- Clients who have a history of violence including criminal charges
- Have co-occurring substance abuse disorders
- Active drug or gang violence in the family and/or neighborhood
- Domestic violence in the home
- Animals in the home
- Active drug activity in the home
- Unexpected or unreported strangers in the home
- Convicted sex offender in the home
- Persistent self-destructive or aggressive behavior with or without conscious homicidal intent
- Client access to or in possession of weapons

These risks are further complicated by:

- Incomplete access to the client's history of violence or criminal history
- This is especially true if you are providing crisis (or mobile crisis) or jail diversion services where you may not have any/or very little historical clinical or criminal information.
- Poor medication and/or treatment compliance
- Your lack of information about recent stability and behavior. Because outpatients are not monitored around-the-clock, you may not be aware of a change in behavior or stability.
- Working solo

Staff Protective Factors

There are numerous staff protective factors e.g., experience, training, managed fear, all the aspects of a safety and the opposite of what we id'd as risks (e.g. fatigue – rested/ supported, poor - good overall approach and demeanor), having a plan in place before you make a home or community visit.

Dog Attack Prevention-Basic Safety Tips

- Keep your distance with known or unknown animals that you encounter.
- Don't approach a strange dog, especially one that's tethered or confined.
- Avoid petting animals, people who choose to pet dogs should always let a dog see and sniff them before petting the animal.
- Never disturb a dog that's caring for puppies, sleeping or eating.
- Never reach through or over a fence to pet a dog. Dogs can be protective of their territory, and may interpret your action as a threat.
- Don't run past a dog. The dog's natural instinct is to chase and catch prey. Don't give them a reason to become excited or aggressive.
- If a dog approaches to sniff you, stay still. In most cases, the dog will go away when it determines you are not a threat.

What to do if….

- A dog threatens you, don't scream. If you say anything, speak calmly and firmly. Avoid eye contact. Try to stay still until the dog leaves, then back away slowly until the dog is out of sight. Don't turn and run.
- You believe a dog is about to attack you, try to create a barrier.
- You fall or are knocked to the ground, curl into a ball with your hands over your head and neck. Protect your face.
- A dog displays aggression towards you, face the animal. Dogs prefer to attack from behind; few will actually attack from the front. Watch the dog, but don't stare at it; a dog perceives direct eye to eye contact as a threat or a challenge.
- There is more than one dog, it may be necessary to back up against a barrier such as a car, fence or wall to keep them from surrounding you. Stay still until the dog(s) back down, then slowly move away while still facing the dog [2].

http://www.richlandhills.com/content/dep-animal/animal-tips.asp#103

Before a community visit always (cont'd)

- Call the client to confirm your visit and who might be in the home and the risks they present, the purpose of the visit. Earlier we also said this is the time to reassess their status

- Consider a neutral, safer site or going in pairs for the visit whenever possible.

- Consider (when possible) whether a change in visit time or place will decrease your risk of danger.

- Have a mental plan and rehearse it

- Maintain the proper mind-set….I will survive.

Upon arrival and during the visit:

- Back into driveways or park facing direction of traffic for quick escape

- Observe your surroundings and stay alert – never let your guard down

- Keep your head up, hands free, walk with confidence and purpose

- Observe bushes, blind areas in buildings and stairwells

- Stay near Lights, People, Action – avoid being in isolated areas

- Always maintain personal space

- Know where the exits are: find out the quickest and safest route in and out of the buildings that you will be in BEFORE you enter the building.

- Avoid darkened stairwells or isolated parts of the building.

- Listen by the door before you go in, if you hear anything concerning, don't enter!

- Immediately reassess the client and situation.

- Stay closest to the door in the client's home – avoid meeting in the kitchen.

- Leave if you are asked to leave or feel unsafe.

- Trust Your Instincts and don't stay if you see anything suspicious.

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, 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
- Required attendance at programs/activities

[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 clients sets the stage for a safe environment. Your behavior, words and actions can trigger a client 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 clients - that may be a result of transference or counter transference, you need to address it to avoid inadvertently triggering them.

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 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 clients.

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

Whatever verbal technique you decide to use:

Avoid power struggles. Always consider how you request or respond to a client – 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, thus they can't engage in verbal interventions. 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.

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

Personal Preferences

Other:

Personal Safety in the Community Setting

Most of you provide services in the community setting. This increases your risk of becoming a victim of crime. Remember, crime is rarely a random act. Criminals have a process for selecting their victims. They **Watch, Test, Select, Isolate** prior to committing a crime.

General safety measures to reduce your risk of becoming a victim of crime when making community visits include the following:

Before a community visit always,

- Carry a fully charged phone, whistle or personal alarm
- Make sure car is prepped and ready - gas and tires are filled
- Pick the safest travel route
- Learn the criminal, illegal and unsafe activities of the areas you will be visiting. The local PD is a great resource for information about current activities.
- Consider your travel routes and if you can avoid traveling through high crime areas, avoid them and keep your car locked during travel. Stay as visible as possible. Avoid tunnels, parking garages, and other isolated sites whenever possible.
- Dress for safety – jewelry to a minimum, no heels and Don't Flash Cash
- Leave a schedule with names, locations and times of where you will be

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

Verbal overdosing – keep saying "yes"; offering no more than two options – based on personal preferences of the person; reducing arousal – deep breaths, reducing 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** (impending court date, family emergency, etc) because they are often triggering events. And, they happen pretty routinely with your clients. They may be asking to go out for shopping trip and you can't take them right now…or you might be the person telling them that a court date is scheduled, or that you are recommending hospitalization.

It 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?
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 factors:

WHY: Sometimes, these response are related to staff convenience rather that how these responses should have therapeutic value (not necessarily mutually exclusive) – in short, 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.

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 e.g., clenched teeth, breathing hard, loud voice
* 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 clients regularly about what they are thinking and feeling and to pay attention to any change in behavior – even becoming withdrawn, silent.

Safety Assessment for Home/Community Visits

Because you are more typically seeing clients at their homes or in other non-DMHAS settings, you should always assess the client's risk and protective factors.

Prior to a visit in relation to your planned visit: clinically assess:
* Status of treatment compliance and related current mental status
* Status of life stressors and the client's response to them
* Any situations that present risk that have recently occurred or are about to occur and how they've been handled by the client and/or addressed by clinical staff e.g. domestic violence, gang activity
* The purpose of your visit and related issues it may present to increase your risk of harm e.g., do you have bad news?
* The location of the visit and related situational risks

When **traveling by car**:
* Assess the vehicle that you will use for readiness e.g. gas.
* Check your cell phone to make sure it's working and fully charged
* Assess the route you will take and the dangers it presents
* Assess entry and exit routes of the building you will be entering to ensure that you can make a quick escape if needed

Upon **arrival to the location,** immediately survey the scene and assess:
* Animals (known and unknown)
* Unexpected strangers or known people who may present a risk
* Weapons and unsafe objects
* Signs of active SA
* Signs of illegal activity
* Obvious signs of aggressive behavior that may have recently occurred e.g., disarray or a change in the home environment that indicates violence or decompensation

Assessing and Determining the Level of Risk

When you are determining the clinical 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 **b**ehavior that catches your attention. Then, you attach meaning to it based on the **p**erson risk factors and then you put the information (what you heard, saw, who's involved, etc) together in the context of the **s**ituation 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. Being situationally aware is especially important in the community setting because they are not controlled settings. For you personal safety, there are assessments that should occur **before and during** every home or community based visit.

In past CSS reviews, we've focused on the immediate risk – this year we also want you to consider chronic risk:

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

Chronic Long-Term risk means that it can happen in the future. People who are a chronic 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., stopped taking their medications, abusing substances, lost a job or living situation.

24 hour Settings (Brief care/Respite): Short Term – high likelihood within 24 hours

Thinking about *when* dangerous or violent behavior might occur is important because it helps you think and plan ahead. Think not only about specific clients, but consider all the at risk people in context. Specifically, you should be determining out of your total caseload or census:
Who's at risk - e.g., out of 25 clients, 5 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 clients 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 OHSA's Universal Precautions for Violence: **Violence should be expected but can be avoided or mitigated through preparation.**

Planning ahead reduces the risks that you or others will get hurt because everyone knows the plan and has 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.

Staff Communication

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.*

Staff and Client Communication

The 3 W's. 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 client is asked: What can we do to HELP?

This model structures the discussion for you and the client and is a great way to discuss non-emergency planning with clients who are a n immediate or short term risk for dangerous behavior.

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 <u>one thing</u> 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.

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

- Interactions: Staff, other patients, and in 24^0 care settings-visitors
- 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 in 24^0 settings should minimally include:

- Identifying the primary person who will work most closely with the client to prevent an emergency
- 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.

The emergency plan for those of you who are providing community based services can vary according to the location. Know the plan for your location e.g., if you work in the courts, be clear about how an emergency would be responded to and what your responsibilities are.

If you are providing services in the home, typically you would contact the municipal or state police in an emergency. You may be required to contact your MCT also – make sure you are clear about your facility procedure.

Typically, you'll be considering hospitalization in emergency situations and in chronic long-term risk situations, you will consider increased monitoring, structure, support and a variety of other options.
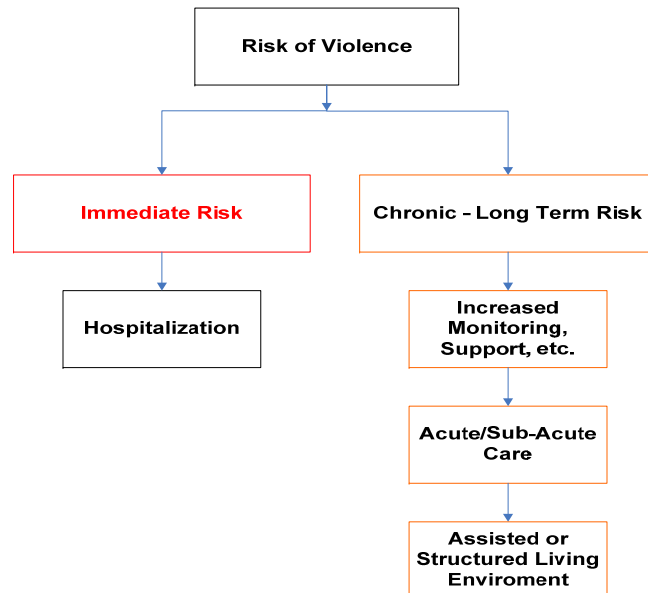
STRATEGIES for ENHANCING SAFETY in the OUTPATIENT-COMMUNITY SETTING

Strategies for Enhancing Safety and Interrupting the Cycle

Communication Barriers

<u>Interruptions and distractions</u> - which happen frequently.

<u>Attentional Narrowing</u> – 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.

<u>Memory overload</u> – 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, in 24^0 care or outpatient clinic or day program settings you have Shift Report. Keeping the information flow going – with all the various people and information – can be especially hard in the community setting.

In terms of planning ahead, **in** 24^0 care or outpatient clinic or day program settings **Shift Report** is an excellent opportunity to share information and plan ahead and should be attended by all of the incoming staff. In the other outpatient settings, **Team Meetings** are the place to share this information. If you do not already structure your shift report or team meetings in the way that we are going to talk about, consider changing it so that it provides the information that you need to maintain safety.

For those clients 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 (24^0 settings—short) or chronic risk)
- Have a **Plan** for reducing the risk AND an emergency contingency plan, for those immediate crisis situations.