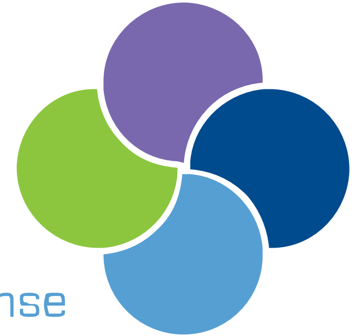
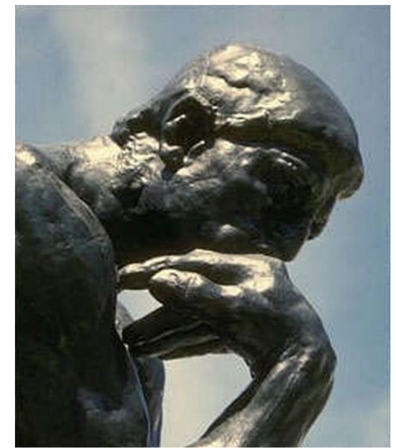
We Care, We Listen, We Respond...24 Hours a Day



Tools and Strategies to Support Clinical Staff:

Management of Patients with Behavioral Challenges

Thoughts

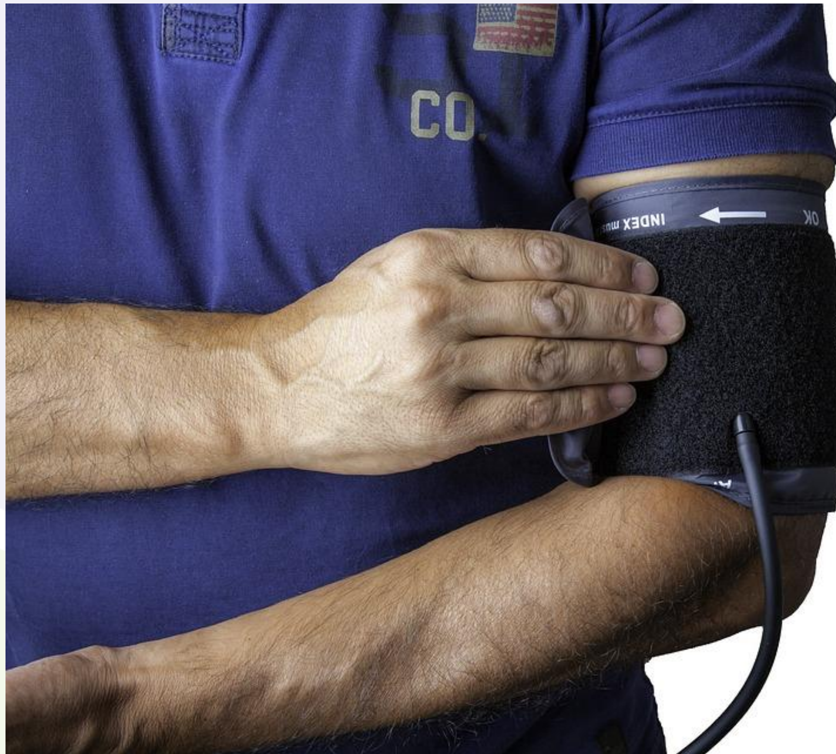


Check all that apply:

- ❑ I am NOT trained to provide therapeutic/emotional care.
- ❑ Psychiatric patients create distractions on the unit.
- ❑ Psychiatric patients create significant safety issues for themselves, staff, family and other patients.
- ❑ Psychiatric patients often utilize enormous amounts of resources.
- ❑ We don’t have good protocols or resources for managing patients with psychiatric needs.

What’s it like for you?

It’s important for us to understand more about YOUR experiences at work.



Frustrations of Staff Working with Patients with Psychiatric Needs

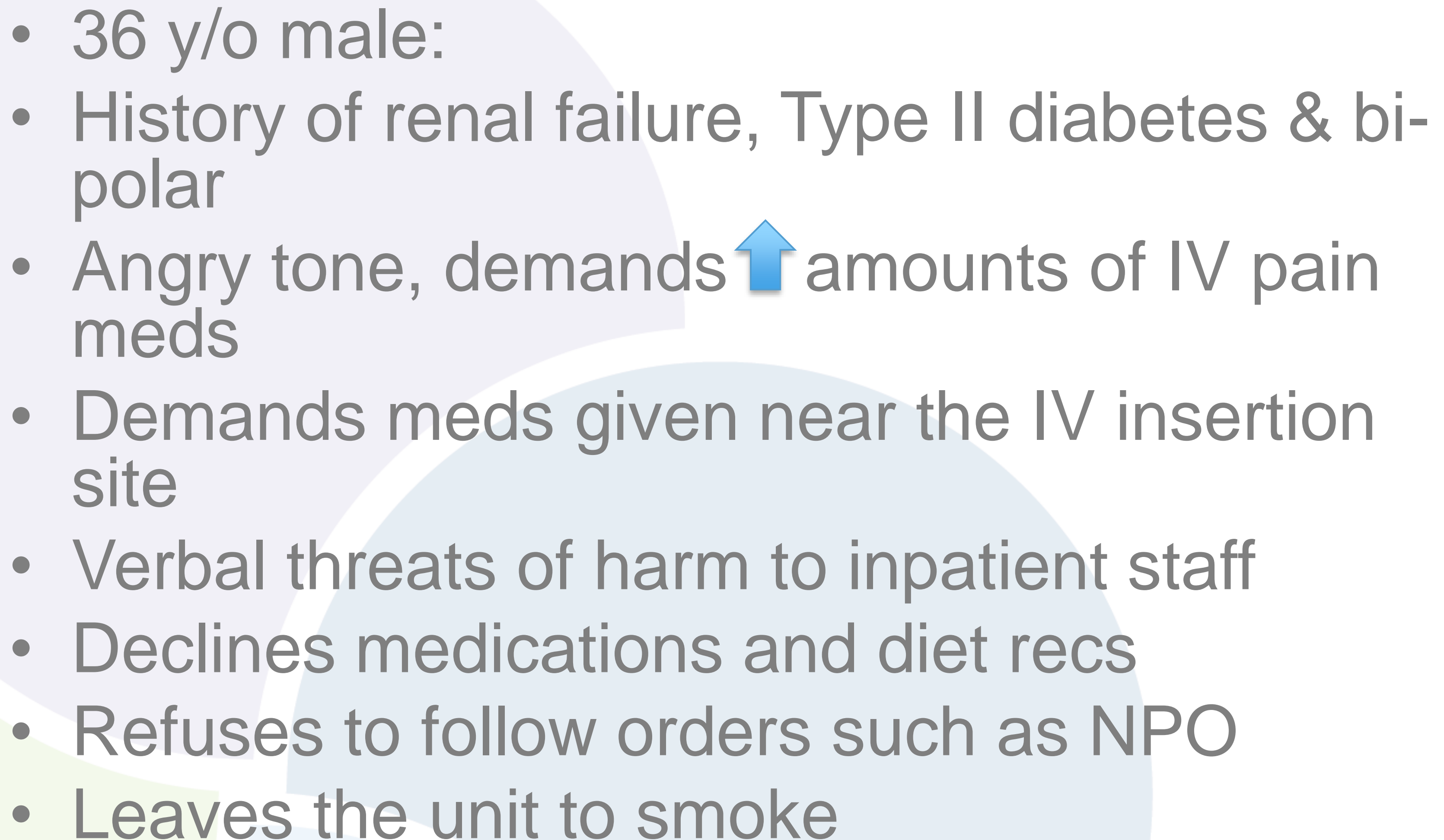
- Lack of support/resources
- Challenges with MD support/presence
- Receiving limited, unclear or misleading information from transferring unit
- Difficulty differentiating patients experiencing withdrawal from patients with psychiatric issues from patients with both

Do You Ever Feel Like This?

We Care, We Listen, We Respond...24 Hours a Day

BHR
Behavioral Health Response

Scenario #1



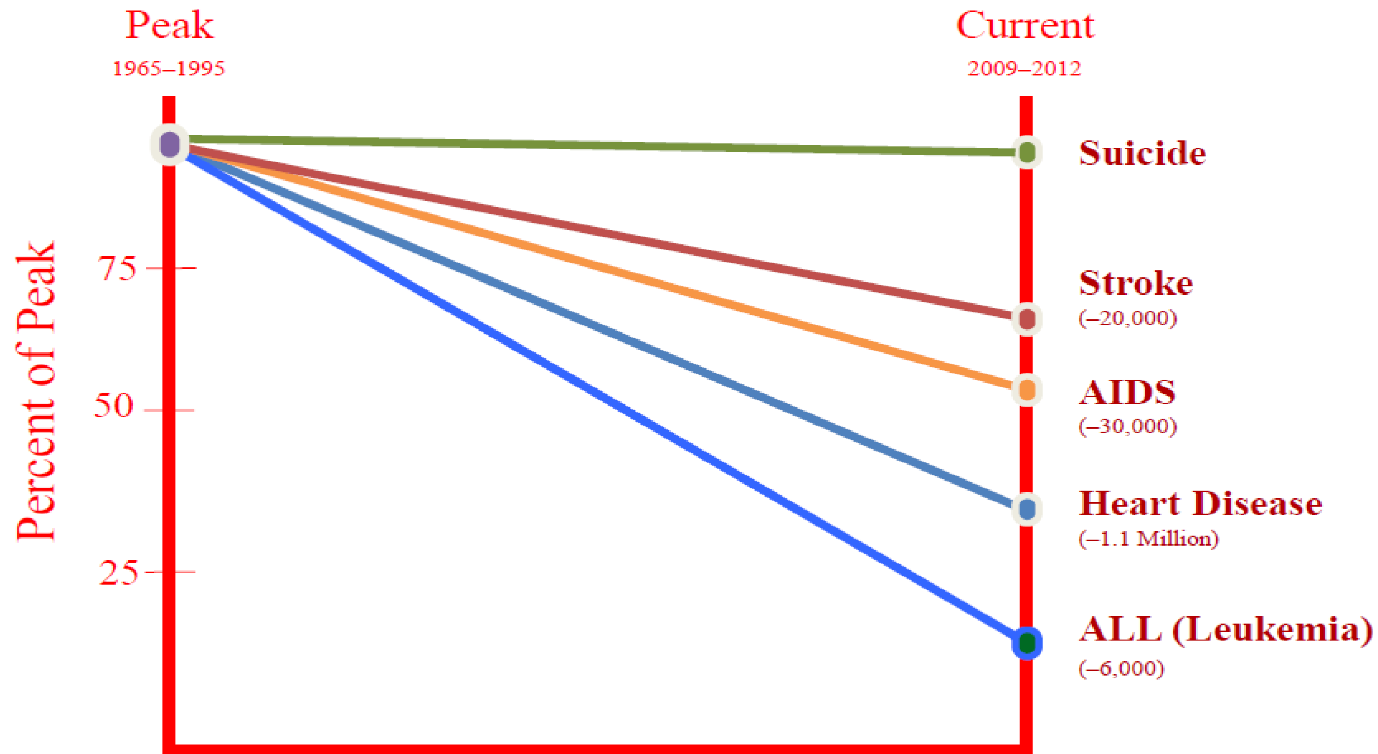
- 36 y/o male:
- History of renal failure, Type II diabetes & bi-polar
- Angry tone, demands ↑ amounts of IV pain meds
- Demands meds given near the IV insertion site
- Verbal threats of harm to inpatient staff
- Declines medications and diet recs
- Refuses to follow orders such as NPO
- Leaves the unit to smoke

Scenario #2

- 24 y/o female pt on involuntary psych hold
- Angry and yelling at staff - escalates throughout day
- Multiple calls to psych MD no adequate resp.
- Pulled out IV, physically pushed staff out of the way, ran out of room and Code White called
- Ran outside of hospital and across busy street
- Police observed pt crossing street & brought her back
- Patient returned to room
- Upon discharge, she was quickly readmitted, given Ativan/restrained

CAUTION !!!
PEOPLE
RUNNING
FREE

BHR
Behavioral Health Response



The Quest for the Cure: The Science of Mental Illness, Thomas Insel, MD, Director of NIMH, 2014 National Council for Behavioral Health.

Lets talk Angels and HARPS

- Psychologists screened, ID’d and dist. HARPS (High Alcoholism Recovery Potential)
- 1 year later, HARP groups significantly better than non HARP
- What was the secret?

Leake and King (1977)

Attitudes, Expectations and Change

- Our attitudes have direct impact on care
- Our expectations impact care
- Our behaviors impact care
- The easiest way to change patient behavior is to change **our** attitudes, expectations and behavior

BUT HOW and DOES IT REALLY WORK?

HOLD THE PHONE MISTER, ARE YOU IMPLYING

OUR ATTITUDES AND EXPECTATIONS IMPACT CLINICAL OUTCOMES?

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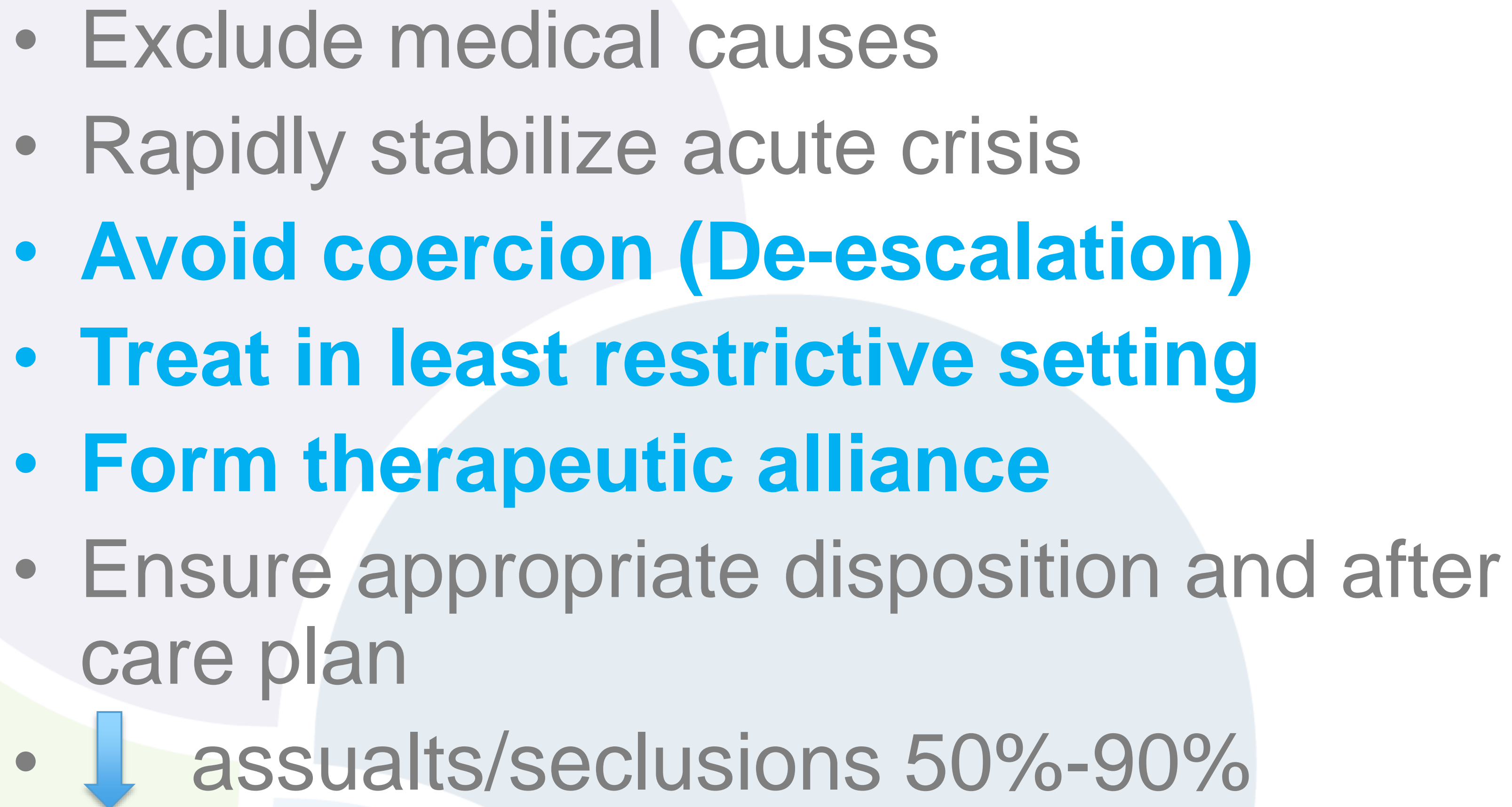
Role of Attitudes/Experiences in Care

1) What role do our own attitudes and patient attitudes play in how care is received?

2) What has your experience taught you?

Psychiatric Emergency Services (PES)- Zeller Model



- Exclude medical causes
- Rapidly stabilize acute crisis
- **Avoid coercion (De-escalation)**
- **Treat in least restrictive setting**
- **Form therapeutic alliance**
- Ensure appropriate disposition and after care plan
- ↓ assualts/seclusions 50%-90%

Our Focus is on RELATIONSHIPS

- Therapeutic Alliance
- De-escalation
- Safety

Therapeutic Alliance = Bedside Manner

- Bedside Manner is a set of:
  - attitudes
  - expectations
  - behaviors

- That enhance the relationship between a clinician and patient.

- And demonstrate compassion in even the most difficult circumstances.

What are you already doing to foster a positive relationship?

Easy Steps To Therapeutic Alliance: *R.E.C.E.I.V.E.*

Respond warmly/positively

Explore need/explain process

Check in and get permission

Expect to go off protocol

Include customer in your thoughts/actions

Validate emotional content

Evaluate and adjust as needed

Respond Positively/Warmly

Making Friends Can Be Easy or Hard

- First impressions are key
- Patients will make decisions about your level of care, attitude and helpfulness based on your tone, words and non-verbals
- Patients will fill in the blanks if we do not provide a supportive presence verbally and emote and validate
- A neutral/business like tone = clinical or uncaring

Explore Need/Explain Process

- What is going on-NEED FIRST
- Introduce the process
- Be brief but clear
- Don't use explanation to limit help
- What's next? Then What?

check in and get permission

- The process is all about including the patient.
- Key in collaborating.
- Develops rapport, reduces :
  - perceived differences in power
  - anxiety for the patient and the clinician.
- We are empowering patients to help us help them.

Expect to Go Off Protocol

"I don't want you to take my blood pressure! I just want to talk to somebody?"

What would you do if this happened?

DON'T LET PROTOCOL TIE U DOWN

- Divert from protocols based on need
- Good Bedside manner and flexibility will help you get all the protocol pieces and information gathering done
- Connect with the information/patient

Include Patients in Your thoughts and Actions

- Comfort collaborating is key
- Think out loud
- Communication is a two way street
- Our expertise resides in making this connection

Validate Emotional content

- Relationship building: developing a safe experience
- Validating emotional experiences builds safety
- Awareness of your emotional reactions is key
- Get beneath the content!

- There is no WRONG emotion but if we do not validate the emotion, it can go wrong quickly

AT NIGHT I TELL FOLKS THAT NONJUDGMENT AND UNDERSTANDING ARE VITAL

BUT DURING THE DAY, I AM A JUDGMENT MACHINE

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evaluate and adjust

Connection and Communication Check

It is OUR responsibility to evaluate efficacy and adjust our approach to meet our PATIENT NEEDS.

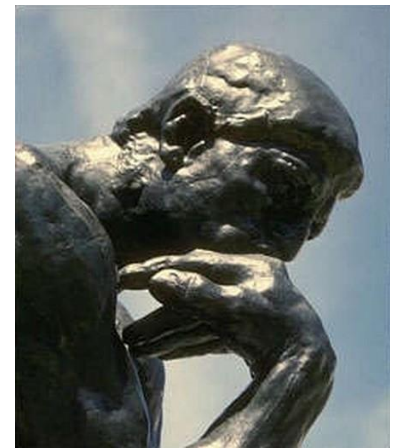
Patients cannot fail, but providers and systems fail all the time

LANGUAGE

Implicit Bias	Patient Centered
• Commit Suicide	• Attempted or Died by Suicide
• Non Compliant	• TX is not adhering
• Axis II/PD	• Emotional dysregulation
• Resistant	• Engaged/assertive/strong
• Manipulative/gamey	• Needful, help seeking, persistent, engaged

*Client-centered language is Evidence Based

Back to Thoughts



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Frustrations Revisited

- Lack of support/resources
- Challenges with MD support/presence
- Receiving limited, unclear or misleading information from transferring unit
- Challenges differentiating patients experiencing withdrawal, patients with psychiatric issues or patients with both

What Does Therapeutic Alliance Have to Do with De-escalation and Safety

- The best de-escalation is prevention
- Good clinical care = safety
- CLINICAL = RELATIONSHIP
- When patients' needs are met, escalation is unlikely
- Frame agitation as unmet need/treatable condition first – change the game.
- But even best prevention is not perfect

What is Agitation?

Agitation is a behavioral condition with many causes, often typified by repetitive and non-goal oriented motor activity:

- Foot tapping
- Hand wringing
- Hair pulling
- Fidgeting/fiddling
- Excitability

Agitation is a Continuum and Fluid

Brøset Violence Checklist (BVC)

6 Item instrument to evaluate risk/agitation

Characteristics

- Confusion
- Irritability
- Boisterousness

Behaviors

- Verbal threats
- Physical threats
- Attacks on objects

0 very low risk

3-6 – prevention needed

Broset Violence Checklist

Broset score will serve as "6" vital sign for ED patients that are combative, Code White or suicidal. Obtain and document a Broset score upon patient arrival at Triage/Desk. Re-evaluate and document a Broset score every 2 hours or < as ordered or at discretion of RN. Obtain and document a Broset score on any existing ED patient that has a behavior change (exhibiting any of the above listed behaviors or Code White) and re-evaluate/document every 2 hours thereafter.

Interpretation Key		
Confusion:	Appears obviously confused & disoriented. May be unaware of person, place, time.	
Irritability:	Easily annoyed or angered. Unable to tolerate the presence of others	
Boisteriousness:	Behavior is overtly "loud" or noisy. For example slams doors, shouts out when talking, etc.	
Verbal Threat:	A verbal outburst which is more than just a raised voice and where there is a definite intent to intimidate or threaten another person. Example verbal attacks, abuse, name-calling, verbally neutral uttered in a snarling manner.	
Physical Attacks:	Where there is definite intent to physically threaten another person. For example the taking of a an aggressive stance, the grabbing of another person's clothing, the raising of an arm or leg, making of a fist or modeling of a head-butt directed at another.	
Attacks on Objects:	An attack directed at an object and not an individual. For example the indiscriminant throwing of an object, banging or smashing windows, kicking, banging, or head butting and object, or the smashing of furniture.	
Total Points:	0	low risk for violence.
	1-2	moderate risk for violence and preventative measures should be taken
	3-6	high risk for violence and immediate preventive measures should be taken and plans about how to manage an attack made
Score:	**No = 0**	**Yes = 1**

Broset Violence Checklist

	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Time:	Time:	Time:	Time:	Time:	Time:	Time:	Time:	Time:
	Score	Score	Score	Score	Score	Score	Score	Score	Score
Confusion									
Irritability									
Boisterous									
Verbal Threat									
Physical Attack									
Attacks Objects									

Who is most likely to be aggressive?

- History of violence
- Command hallucination
- Acute mania
- Active intoxication
- Psychosis/mania
- Confused/disorganized/disoriented

Covers most BUT NOT ALL!

Best Practices in Evaluation and Treatment of Agitation (BETA)

BETA-Helping Patients (and staff) Stay Calm

3 Steps:

- Verbally Engage
- Establish Collaborative Relationship
- Patient De-escalates

Note: focus is on patient's control, not ours

4 Goals of BETA

- Ensure **safety** of **ALL**
- Help patient manage emotions/regain **control**
- AVOID **restraint** whenever possible (more often than not)
- AVOID **coercive** interventions that escalate aggression

Key Points

- More time spent on relationship and BETA reduces MUCH time/safety lost with restraint
- Helping a patient manage emotions MEANS we must be aware and manage our own
- Patient's behavior has internal and external causes
- Make the environment the **solution**, not the **problem**
- **SLOW DOWN**

10 Guidelines of De-escalation

1) Respect Space
2) Don't Provoke
3) Engage Verbally
4) Be Concise
5) Identify Wants/Feelings
6) Listen Closely
7) Agree to Disagree
8) Set Clear Limits
9) Offer Choices
10) Broach Subject of medications

Challenges

- Some of us are more comfortable with rapport, relationship and collaboration
- Some of us are more comfortable with limit setting and establishing structure
- BOTH are important & BALANCE is key

Which are you more comfortable with?

Ten De-Escalation Commandments

I You Shall be non-provocative:
- Calm demeanor, facial expression
- Soft-spoken with no angry tone,
- Empathetic-genuine concern
- Relaxed stance-arms uncrossed…
  …hands open…knees bent

II You Shall respect personal space:
- At least 1 patient leg or 2 patient arm lengths away
- Normal eye contact
- Offer a line of egress, don't let patient get between you and exit
- Expand space if patient paranoid
- Move if told to do so

III You shall establish verbal contact:
- Tell them who you are,
- Establish you are keeping them safe,
- You will allow no harm
- You will help them regain control
- ONE COMMUNICATOR

IV You Shall be concise:
- Use short phases or sentences
- Repeat yourself, repeat yourself
- Get the patient's attention…don't confuse

V You Shall identify their wants and feelings

VI You Shall set Expectations:
- Set limits
- Offer choices, propose alternatives
- Establish consequences
- Use positive reinforcements

VII You Shall listen:
- Don't argue
- Don't up the ante
- Check understanding

IX You Shall agree to disagree

X You Shall debrief with patients and staff

The Art of Introduction

- Your name/title/role
- Who else will be coming in
- Patient ID preference
- Check in and get permission
- Orient to process and time
- Use FREE info and identify needs
- Use orientation process as inviting way to set limits, i.e. “We have 3 asks …”

Application

1) What are we already doing well?

2) Challenges?

3) What are ways we could incorporate this into the day to day?

Patient Safety = Staff Safety

BHR
Behavioral Health Response

Prepared/Vigilant vs Fearful/Hyper-vigilant

This may seem counterintuitive but FEAR provokes AGGRESSION and makes us less safe.

The opposite is also true. Complacence and lack of vigilance makes us less safe.

We need to be prepared and aware, not frightened and defensive.

Safety Do's

- Stand about 4 – 5 feet away, to the side, knees bent slightly
- Stay close enough for rapport
- Observe for
  - Tense posture
  - Provocative behavior/staring
  - Aggressive stance
  - Hyper vigilance
  - Signs of agitation
- Be Aware: your own emotions/triggers/ behaviors

Do's Continued

- Allow family members to stay (caveat)
- Limit visitors and explain who/why
- Be friendly but not overly familiar
- Trust your gut but do not over-react
- Monitor your own reactions/responses
- Be kind – kindness is never a problem
- Ensure you have safe egress

Safety Don'ts

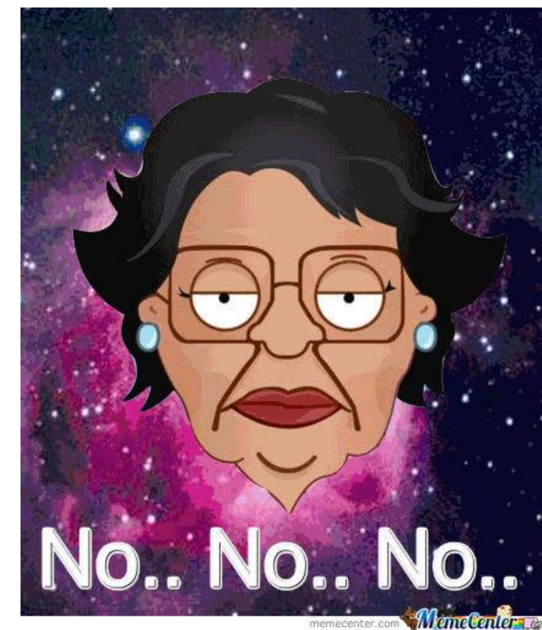
- Avoid excessive eye contact (stare at chin)
- Don't enter personal space without asking permission
- Don't turn your back
- Don't approach from blind spot
- Don't argue or defend
- Don't react to personal attacks/insults
- Don't ignore threats

When Threats Occur

First Steps

- Calmly inform patient threats are not tolerated BECAUSE it is unsafe for patients and staff
- "What can I do to help"
- Offer solutions first, then limits/consequences
  - We can provide this . .
  - Or this
  - But if that does not work, we need to do x
  - Tell me what you would like to do?
- Do not press, give space, offer to come back after they have thought about options

Things That Escalate (Handout)



- Snappy retorts
- Intolerance of complaints
- RUSHING
- Ignoring requests for information
- Failure to recognize physical or verbal signals
- **Overreaction to people or situations**
- **Ignoring or minimizing threats**

Things That Help (Handout)

- Showing concern & respect
- Calm, slow, patient
- Soft speech
- Validate concern
- Non judgment
- **Focus on changing environment**
- Focus on options and "what do you need?"
- TAKE CARE OF PATIENT NEEDS

New Scenario #1

- 19 college female who is suicidal, hx of cutting, depression. Youth stated “I would kill myself but didn't have any pills or anything else to do it with.”
- Divorced parents, mom overpowering and overbearing to youth and ex spouse, speaking very loudly, could hear mom in hallway with door closed.
- Mom talking in demeaning manner about youth and ex spouse in front of youth and ex spouse.
- Mother escalating and youth shut down, not talking, sitting with legs drawn up, head down, no eye contact, no verbalizations.

New Scenario #2

Autistic 26 y/o male:

- Escalating behaviors at home, becoming more defiant with routine activities at home;
- At home has started throwing objects, yelling and hurt a siblings with thrown object;
- In room is loud, pacing around in room, yelling at parents “I don't need to be here, take me home, you make me so mad, This isn't my fault, I'm getting out of here.”

New Scenario #3

- Large male pt.
- Hx of bipolar disorder.
- Stopped taking medication one month ago.
- Evaluated - meets criteria for involuntary admission – transfer delayed indefinitely.
- Will not speak to anyone.

Wrap Up

- Not all of these things work all the time
- BUT they work better than any other approach
- But we need to learn from you what works better and what doesn't

What can we do to support you with this approach?