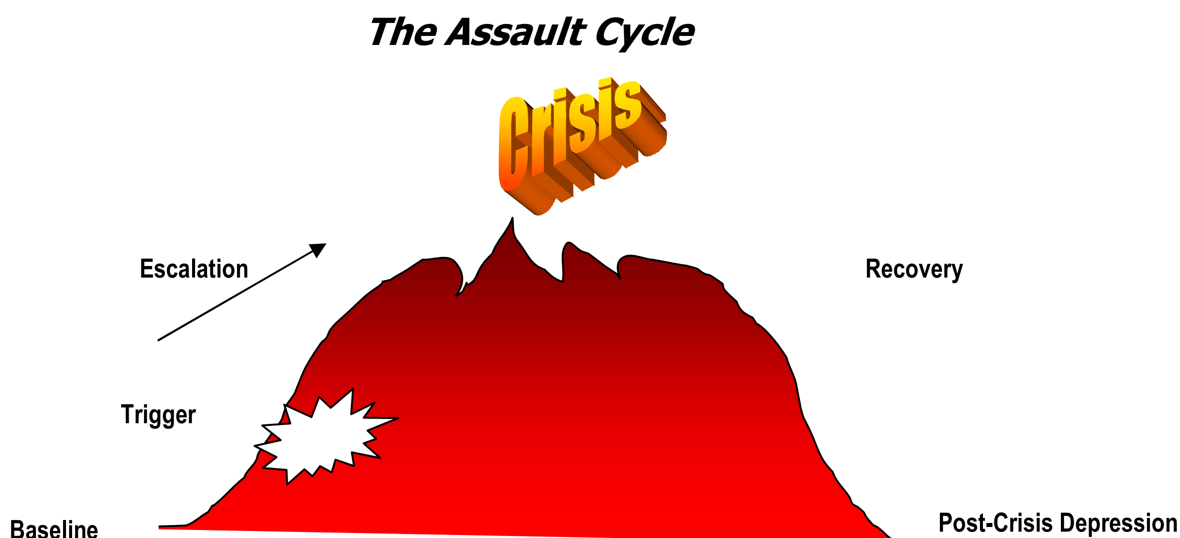
Assault Response for Healthcare Providers

Assembly Bill 508 (AB508) Guidelines

Compiled by Terry Rudd, RN, MSN

The Assault Cycle



4.0 Contact Hours

California Board of Registered Nursing CEP#15122

Compiled by Terry Rudd RN, MSN, CCRN

Key Medical Resources, Inc.

FAX: 909 980-0643 or

Email:KMR@keymedinfo.com. Put "Self Study" on subject line.

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Updated 1/2016

Title: Assault Response for Healthcare Providers: AB508 Guidelines

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Title: Assault Response for Healthcare Providers: AB508 Guidelines

Self Study Exam 4.0 C0NTACT HOURS

Choose the Single Best Answer for the Following Questions and Place Answers on Form:

1. In some states, such as California, it is required for hospital personnel to:
   a. Document assault only if there is personal injury.
   b. Notify local law enforcement within 72 hours if there is any assault or battery.
   c. Initiate training for assault response training once an event has occurred.
   d. Train only security personnel in techniques for assault prevention.

2. Which statement listed below is **not** true:
   a. Emergency room personnel rarely have experienced assault in their career.
   b. The team approach is very important when working with the assaultive client.
   c. Hospital workers can be at increased risk for assaultive incidents.
   d. Assault can occur from clients and families.

3. Which of the following statements are true related to general safety measures:
   a. Maintain personal space about approximately one arm's length.
   b. Allow the client to regain self control.
   c. Allow yourself an exit.
   d. All of the above are good safety measures.

4. Which item listed below IS NOT considered contraband?
   a. Keys
   b. Scissors
   c. Compacts with glass mirrors
   d. Hearing aid

5. Which description below could pose a threat to the healthcare worker with a potentially violent client?
   a. A stethoscope around the neck.
   b. Short nails
   c. Having others around you.
   d. Comfortable shoes.

6. Which description below IS indicative of assaultive behavior?
   a. Obnoxious behavior
   b. Name calling
   c. Client scratching
   d. Client ignores what you say

7. Which description below best defines assault?
   a. Restraining someone without legal justification.
   b. An attempt or offer to do violence to another with our without battery.
   c. Calling someone a name.
   d. Allowing someone to take your blood pressure.

8. In working with potentially violent individuals, which concept is MOST important for the healthcare worker?
   a. Restraining the client to protect you.
   b. Prevent and protect injury to yourself and the client.
   c. Harm the client only if there is a threat to others.
   d. Restrain the client until help arrives.

9. What is the most common occurrence to begin the assault cycle?
a. A triggering event.
b. A crises that occurred in their past.
c. Recurrent depression.
d. Admission to a medical facility.

10. During the crises period of the assault cycle, which statement is true?
a. Behavior escalates.
b. The person is exhausted and returns to baseline levels.
c. Energy expenditure is very high.
d. Depression is manifested.

11. Which situations listed below does the assault pattern not apply?
a. Person with seizures
b. Individual using hallucinogens
c. The person who is a psychopath
d. All of the above

12. One of the most effective ways to prevent injury to yourself during and potential assaultive situation is to:
a. Confront the assaultive person.
b. Get you and others out of the way.
c. Tell the person to please sit down and relax.
d. Tell the person who is angry that this must be a very difficult situation.

13. The most therapeutic goal for the client after crisis is to:
a. Reach a higher level of functioning than before the crises.
b. To not shout or scream.
c. Is to establish a level of functioning that was present at the onset of the crisis.
d. Communicate with their families about how awful the crisis was.

14. Which of the following are reasons that persons in the hospital setting might express anger?
a. Their cognition is impaired from medications.
b. They are worried about what might happen to them.
c. They have fear of the unknown.
d. All of the above could trigger anger.

15. Which of the following is true?
a. Angry persons will always raise their voice.
b. Most communication is nonverbal, the healthcare worker should assess nonverbal cues for anger.
c. It is easy for the healthcare worker to identify the angry person.
d. There are predictable ways in which persons express their anger.

16. Which techniques, listed below is an important defusing technique?
a. Focus on the client, not the rules.
b. Stand close to the client.
c. Ask the client to stop talking so that they may listen to what you have to say.
d. Use threatening body language to encourage the client to stop the behavior.

17. Which of the following is the most important strategy to avoid physical harm?
a. Safety first.
b. Allow angry persons space.
c. Train staff members on the techniques.
d. When possible physically restrain.

18. Physical maneuvers to diffuse violent behavior is:
   a. A preventative first step.
   b. The last resort and used only when other tactics have failed.
   c. The preferred method to prevent injury to others.
   d. Should be attempted before verbal de-escalation methods have been tried.

19. An appropriate techniques to use if someone is biting you is to:
   a. Pull away and shout for help.
   b. Bite the client back.
   c. Move towards the bite.
   d. Hit the client firmly on the arm.

20. When someone is grabbing you, release the grab by:
   a. Finding the weakest part of the grab and pull up or down at that location.
   b. Providing a forceful blow to their hand.
   c. Biting the hand.
   d. Pulling away as hard as you can.

21. A chemical restraint is defined as:
   a. A medication given for pain.
   b. A general anesthetic.
   c. A restraint on the wrist.
   d. A medication used to control behavior or restrict the client's freedom.

22. Chemical restraints MAY NOT:
   a. Be a PRN order.
   b. In any way control the client's behavior.
   c. Be used with other interventions.
   d. Be discontinued sooner than 48 hours after initiation.

23. After a violent incident occurs, the healthcare worker must:
   a. Take the rest of the shift off.
   b. Complete an incident report.
   c. Talk with others about the event.
   d. Talk with the client who harmed them within 24 hours.

24. Post incident debriefing includes:
   a. Reviewing the incident with the team.
   b. Try to determine what might have been done different.
   c. Discussion with your manager or Human Resources if you need assisting in dealing with the situation.
   d. All of the above.

25. Which items should be included in documentation of a violent incident?
   a. Description of the client's behavior.
   b. Respiratory and mental status change assessments.
   c. If used, what types of restraints were used.
   d. All of the above.

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Self Study Exam 4.0 C0NTACT HOURS

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Objectives

At the completion of this program, the learners will:

1. Verbalize general and personal safety measures.
2. Discuss the assault cycle and stages of a crisis.
3. Discuss Precipitating factors to violence.
4. Discuss legalities as it relates to interventions
5. Assessment of cues
6. Verbal de-escalation strategies
7. Discuss and demonstrate various physical evasive techniques
8. Discuss various aspects of restraints.
9. Post incident support and documentation.
10. Complete written competency at a 70% competency.

Introduction

Persons who work in the healthcare industry are at risk for assaultive events as clients and staff have high risk stressors. In California, AB 508 is a law that requires all hospitals to conduct a security and safety assessment plan to protect personnel, clients, and visitors. All hospitals are required to report any assault or battery to local law enforcement within 72 hours. All hospital employees assigned to the emergency department will receive training on how to handle emergency room violence.

Preventing assaultive events before they occur is the key and verbal de-escalation techniques may help in preventing injury to the client or yourself. This packet emphasizes verbal strategies and does cover aspects of hands-on techniques to prevent harm.

Minimum Training Requirements of AB508 in California

- General Safety Measures
- Personal Safety Measures
- The Assault Cycle
- Aggression and Violence Predicting Factors
- Obtaining a Client History from a Client with Violent Behavior
- Characteristics of Aggressive and Violent Clients and Victims
- Verbal and Physical Maneuvers to Diffuse and Avoid Violent Behavior
- Strategies to Avoid Physical Harm
- Restraining Techniques
- Appropriate Use of Medications as Chemical Restraints
- Employee Resources
- Incident Debriefing

The law does not specify how the training is conducted, length or frequency. Usually, it is helpful for staff to have re-training annually. A competency tool is provided at the end of the module.

Emergency Room Violence

- 58% of respondents reported injuries to staff, visitors or other clients related to violent acts; in 41% of the cases, the weapon used was a gun.
- 70% of emergency room nurses reported at least one assault during their career, and 36% of the nurses had been assaulted at least once during the prior year.

The Team Approach

The team approach is so very important. The team member who has the best relationship with the assaultive client is the one who talks and leads the intervention. Training allows each team member to see the big picture. Each team member understands what the process is and what the goal is. Communication is the key. Team members must practice together. Team members must communicate expectations before, during, and after the incident. Post crisis review and evaluation by team members improve performance.

General Safety Measures

"Don't Make the Situation Worse"

The main goals of responding to assaultive behavior are:

- Allowing the client to regain self-control.
- Allowing the client to return to sequences of the care plan.
- Preserving the client's rights.

Position yourself for safety.

- Personal Space - Maintain a distance of at least two arms' lengths between you and your aggressor. This will allow you reaction time from attacks such as grabs, strikes and lunges.
- Stance - Angle your body about 45 degrees in relation to the individual. This stance not only reduces your target size in the event of an attack, but also prepares you to escape when +necessary.
- Place your hands in front of your body in an open and relaxed position. This gesture appears non-threatening and positions your hands for blocking and counterattacking if the need arises. Avoid crossed arms, hands in the pocket, or arms behind the back since it not only puts you at a tactical disadvantage, but also can be interpreted as negative body language.
- If possible, casually position yourself behind a barrier such as a sofa, desk, large chair, counter, table or other large object when possible.
- Allow yourself an exit.

Assess and Remove Potentially Harmful Items in the Environment

Common Contraband Items:

Compacts with glass mirrors	Mouthwash or cleansers that contain alcohol	Pencils
Glass containers	Scissors.	Pens,
Picture frames with glass	Staples	Combs
Hair dryers	Stickers	Eating utensils
Curling irons	Cardboard greeting card covers	Knives
Razors	Metallic parts of greeting cards	Forks
Keys		Spoons

Personal Safety Measures

- Don't wear items around your neck -Avoid ties, stethoscopes, jewelry and name badges that can be used as a noose.
- Don't divulge personal information about yourself.
- Give yourself access to exit.
- Have others around you.
- Inform co-workers if there is a potential threat.
- Isolate agitated persons (client, family, visitors)
- Self Assessment
  - Nails short?
  - Comfortable clothing and easy to move?
  - Functional shoes?
  - Keys in a safe place?

Legalities

What constitutes assaultive behavior?

Assaultive behavior is NOT obnoxious behavior, name calling or ignoring.

Assaultive behavior IS an immediate risk of injury to you or the client that would require some form of medical attention. Behaviors such as hitting, kicking, scratching, biting, throwing objects or spitting (if the person has hepatitis or HIV) are considered assaultive.

The person assaulting must have the ability to injure another, be close enough to injure or show intent to injure immediately

There are three primary legal (moral and ethical) considerations when providing restraint and/or involuntary treatment for a client:

- The rights and needs of the client,
- The duties of the health care providers,
- The responsibility for protection of involved third parties.

General Terms

Assault is defined as 1) an unlawful physical attack upon another; 2) an attempt or offer to do violence to another, with or without battery, as by holding a stone or club in a threatening manner.(5) Thus, "threat" – alone – can be considered an "assault."

Battery is defined as an unlawful attack upon another person by beating, wounding, or even by touching in an offensive manner. Checking a person's pulse without their permission may be considered "battery" by some clients. Members of some religions consider it extremely offensive to be touched by a person of the opposite sex; or for anyone to touch the head of a child. Thus, simply touching persons, without first obtaining permission to do so, may be considered "battery."

False imprisonment is defined as restraint without legal justification. False imprisonment is considered a civil law and does not require violent abduction. Its equivalent in criminal law would be "kidnapping." The mere threat of confinement, combined with only an apparent ability to accomplish confinement, and some limitation of movement (i.e.; a closed door), is sufficient to uphold a charge of false imprisonment. However, false imprisonment cannot be claimed if the client consents to being confined.

Simple assault - if the person threatens and is close, has the ability, has the intent and the outcome of the assault will likely require no medical attention other than first aide. Threats to slap, pinch or scratch are examples.

Simple assault and battery - person then carries out the threat and makes contact. No medical attention other than first aide is required. Simple assaults may be diffused by distraction or walking away. Hands on interventions as a rule start at the aggravated assault level. In other words, if a client threatens you but hasn't touched you, you cannot touch the client.

Aggravated assault - if the person threatens harm and makes contact such that medical attention is needed. Examples are eye gouging, hitting, and choking.

Competence is defined as the capacity or ability to understand the nature and effects of one's acts or decisions. And, for all practical purposes, a person is considered to be competent until proven otherwise. Laws governing competence and the right to refuse medical treatment vary widely from state to state. Universally, however, the determination of competence generally depends upon four observable abilities:

- The ability to communicate a choice.
- The ability to understand relevant information.
- The ability to appreciate the situation and its consequences.
- The ability to weigh the risks and benefits of options, and rationally process this information, before making a decision.

There are situations in which the interests of the General Public ("State Interests") outweigh an individual's right to liberty:

- The individual is threatening self-harm or suicide.
- The individual presents a threat to the community because of contagious disease or physical dangerousness.
- The individual presents a specific threat to other people (third parties).
- In these cases, individuals may be restrained and treated against their will.

Consent is defined as the voluntary agreement of a person possessing sufficient mental capacity to make an intelligent choice to do something (or not do something), in response to a proposition posed by another.(2) Consent is generally considered to be either expressed or implied.

Expressed Consent is defined as positive, direct, unequivocal, voluntary verbal or physicalized agreement, and is a more absolute and binding degree of consent. Implied consent is defined as signs, facts, actions or inactions, which support the presumption of voluntary agreement. Thus, a client who personally calls 9-1-1 could be considered as having implied a consent for evaluation and care.

Responding to assaultive behaviors means the primary care plan objectives are not being met. It means whatever plan B was, is not effective. The goal is to get the client to regain self-control and re-enter the primary care plan objectives while protecting the client's civil rights.

Assaultive behavior response is not an isolated set of techniques. If staff is constantly dealing with assaultive situation, then the staff needs to seriously review the primary care plans.

It is essential that you respond in a manner to protect injury to yourself and the client. You have to use techniques that are preventative and evasive. If you use techniques that cause harm to the client, you may be liable for assault, battery, loss of license and legal action.

The Assault Cycle

You and the client go thought the same phases!

<u>Baseline Behavior</u> – The standard behavior observed with the client.

<u>Trigger Event</u> – Something bothers the person. Physical and mental processes increase.

- Observe to spot changes in the client
  - Quiet person may pace
  - Pacing person may sit still
- If the triggering event is not dealt with, escalation occurs

<u>Escalation</u>

- Person thinks angry thoughts
- Body mobilizes for fight or flight
- Increased heart rate, respiration
- Person may pace, yell, throw things or
- Person may become tensely quiet.
- If left unchecked may escalate to crisis

During Escalation Stage:

During the escalation stage, assess the motive. Is the person fearful, frustrated, manipulative or intimidating? This is time to encourage the person to request medication.

<u>Crisis</u>

- Energy expenditure very high.
- Person cannot sustain this level of output for long
- As crisis passes, person will enter a stage of recovery.

During the crisis stage you must keep the crisis communication ongoing and observe the reasonable force guidelines. Remember due to the tremendous output of energy, the crisis will end.

Recovery

- Body and mind return to baseline levels.
- Person is still vulnerable and can re-escalate

During the recovery stage, avoid lengthy conversations. Do not blame or chastise the person. Honor requests for being alone (with observation). The person could still re-ignite and start back into the crisis stage. This is a poor time for medication because of the post-crisis depression that follows.

Post Crisis Depression

- Person is exhausted and body is below the baseline level.
- Pulse and respiration lower than normal.
- Depression accompanies fatigue.

The post-crisis depression is a time where more engaging verbal techniques may be used. Some people will not want to talk. Close supervision is required at this time. The body is physically spent and will drop below baseline levels. Medication could place a person at risk of too low of a blood pressure or respiration. Try and help the person understand what they perceived as out of control in their environment and suggest alternatives. Return the person to the treatment plan.

Situations where assault pattern does not apply:

There are times when an assaultive event may occur without warning. This may happen with the client who has seizures, is on hallucinogenic drugs such as LSD, PCP, or mescaline or has a severe mental disorder. Anticipating the potential for these clients may prevent you form harm.

Other patterns leading to assault:

- Fear – will fight if safety concern.

  Fearfulness can be reduced by approaching the person from the side angles and not head on or from behind. Use a calm and reassuring voice. Stay at eye level and not above. Use crisis communication techniques such as short and direct speech. Keep your posture open and non-threatening.

- Frustration – skin will be splotchy, loud voice.
  If the person is frustrated, try and speak with confidence and control. Use good eye contact. Approach directly in front but outside striking range. Be repetitive and firm without threat. You are helping the frustrated person to re-gain control.

- Manipulation – tantrum to escalate the situation
  The manipulative person needs to be dealt with in matter of fact way. Use little eye contact, since attention is one of the main payoffs. Use a "broken record" or "skipping CD" type of speech pattern. Just repeat the expectation, such as, "It's time to return to your home." over and over again. Act detached and relaxed.

- Intimidation – uses calculated threats to get what they want.
  The intimidating person is handled in a matter of fact, emotionless manner. You will state consequences of his or her choices. Be clear and direct. Do not present

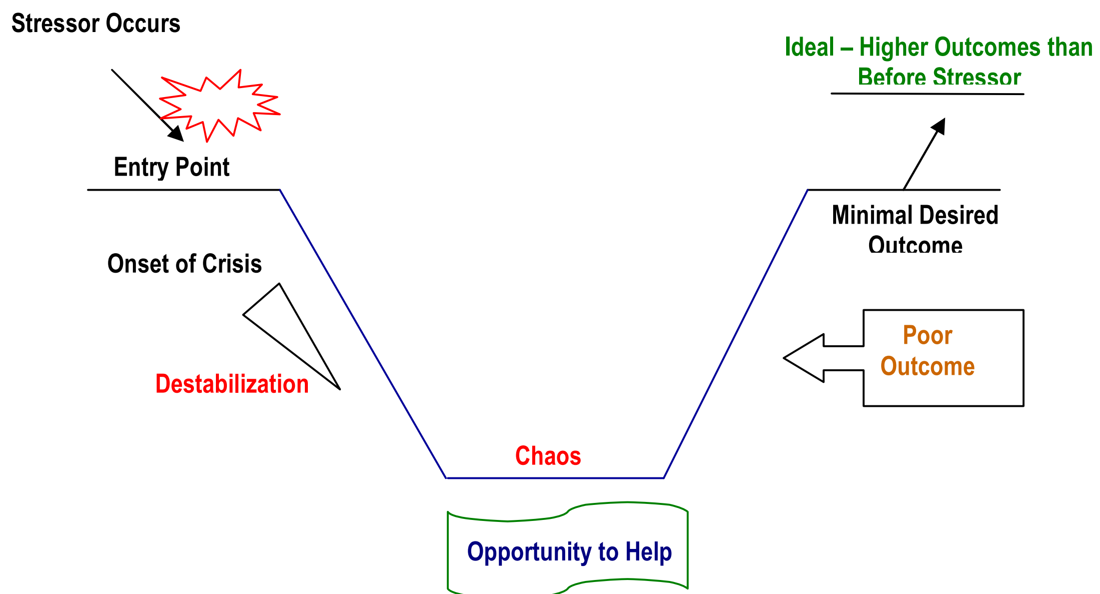
ultimatums. Eye contact is used sparingly. Do not box yourself in the environment. Have an escape route.

<u>Principles to reduce threat</u>

- Match your level of response to the dangerousness of the threat.
- If an assaultive person is alone kicking and screaming, fatigue will eventually win out and an intervention is probably not necessary.
- Crisis communication
  - Short, direct statements.
  - Do not ask open ended questions.
  - Keep voice calm
  - Use the person's name.
- Evade - Get you and others out of the way
- Restraint (a last resort)

Remember that as the person escalates, the capacity to think rationally and use good judgment rapidly diminishes.

Crisis Model



A crisis is an opportunity for someone to obtain help and function at a higher level after the crisis. A stressor occurs, and based on the persons coping mechanisms, if deficient, the person can destabilize and their life can become chaotic. This is a wonderful opportunity for the person to get help. If the individual is unable to attain at least their pre-crisis level, a poor outcome is the result. The goal after a crisis is to reach a high level of functioning than occurred before the crisis.

Aggression and Violence Predicting Factors

- *Clients*
  Clients can exhibit cognitive problems that may occur due to delirium or head trauma. Factors such as pain may be a trigger. Psychiatric illnesses such as mania, psychosis or paranoia may place the client at risk for aggression. Other risks may be substance abuse, younger males and a prior history of violence.

- *Families*
  Families may feel vulnerable and distressed due to fear of unknown, feeling powerless and not having familiarity with the health system. Emotions are raw and a person who feels threatened may suddenly become aggressive.

- *Parents*
  Parents may lose rational perspective when it comes to their child. The parent may want to "protect" the child from pain and may feel powerless to help.

- *Hospital Environment*
  The hospital environment is an accessible, open environment with a wide range of clientele. Situations such as a long waiting time, gaps in communication can promote a situation that may lead the person to aggressive behavior.
- *Alcohol and drug impairment can impair impulse control.*

Obtaining a Client History from a Client with Violent Behavior

Try to determine the cause of the hostility and anger

Pain? Stress? Fear? Grief? Depression?

Suggested Responses:

- *Listen*
- *Reframe*
- *Empathize*
- *Consider Social Worker or other consult.*

Personality Problems? Behavior Problems?

Suggested Responses:

- *Discuss with the person of perceived power defining acceptable behavior.*

Clients, Family or Visitors Hostile?

Suggested Responses:

- *They are communicating vulnerability, overload, fear, helplessness, or powerlessness.*
- *Communicate the Process:*
  - *Identify yourself and role.*
  - *Anticipate their questions. People want to know what to expect.*
  - *Explain the process and procedures in plain terms.*
  - *Acknowledge their emotional pain, feeling s of helplessness and fears.*
  - *Empathize*

Characteristics of Aggressive and Violent Clients and Victims

Motivation for attacks:

- *Irrational behaviors*
- *Dissatisfaction with service*
- *Robbery*
- *Interpersonal conflict*
- *Personal issues*

Signs of Agitation

- *Raised voice*
- *cursing, stuttering, interrupting,*
- *demanding*
- *red face,*
- *clenched fist,*
- *pacing,*
- *rapid breathing,*
- *shaking a finger and pounding the table.*
- *Since 55% of communication is nonverbal, being alert to signs of agitation involves more than what the person says.*

Verbal and Other De-escalating Maneuvers

- Listening is the hero of good communication.
  - Empathize with their situation.
  - Understand their perception of the situation.
  - What do they want that they are not getting?
  - Address their concerns
  - Offer a solution or alternative

Listening: Three Main Listening Skills:
Attending: Giving you physical attention to another person.

Following: Making sure your engaged by using eye contact, un-intrusive gestures (such as nodding of your head, saying okay or asking very infrequent question).

Reflecting: Paraphrasing, reflect back using the feelings of the youth (empathetically).

Other Verbal Suggestions

- Use words or phrases that are neutral. Avoid cultural bias.
- Show respect for the individual.
- Be aware of body language
- Expressions
- Posture
- Gestures
- "I-statements" in place of "you-statements."
  "I see what you mean,"
  "I hear what you're saying,"

Defusing A Situation

- Note when the situation first escalates
  - Louder Voice
  - Fidgeting, verbal sounds
  - Build up of energy
- Be proactive, not reactive. Attend to the client before it gets out of hand.
- The staff needs to be in control by actively defusing the client, family or visitor.

Defusing Techniques

- Avoid arguing or defending previous actions
- Avoid threatening body language
- Calmly but firmly outline limits

- Watch for the Defense Phase
  - If escalating, the client will give more physical cues (louder, more agitated verbalizations.)
  - Staff interventions
    - Reduce stimulation from setting – move to quieter area.
    - Communicate information about delays or area of concern.
    - Give choices
  - As emotions increase, auditory processing decreases.
- Focus on client, not rules
  - They don't care about JCAHO and other agencies.
  - Use phrases for safety, not rules or policies.

- Techniques
  - Plenty of personal space
  - Allow a frustrated person time to vent.
  - Ignore personal verbal attacks.

Verbal De-escalation Procedure

- Remain calm and friendly, be aware of your feelings
- Be mindful of your body language
- Breath slowly and deeply
- Maintain a safe distance and refrain from touching
- Utilize contact and cover principles
- Position yourself so that the client cannot block your access to an exit
- Keep your hands in front of your body in a non-threatening manner
- Only one provider should communicate with the client
- Maintain a soothing tone of voice
- Listen to client's concerns
- Empathize, use positive feedback
- Be reassuring and point out choices
- Be willing to slow down and disengage if appropriate
- Calmly set boundaries of acceptable behavior

Rules for Open Communication

- Allow the distressed person to state the problem.
- Hear the person out.
- Request behavior changes only—what kind of change do you want them to make? Be specific/ non-threatening.
- Remember the Rule of Five—five words or less /five syllables or less. Understand that they are angry, but this is what you want them to do right now.
- Don't ask him/her to feel differently or to change his/her attitude.

Verbal De-Escalation Techniques for the frightened client:

- Speech patterns should be firm, reassuring and confident.
- Explain your actions before doing anything!
- Avoid any surprises. Don't make things worse! You will increase chances of the client becoming physical if your communication adds to their perceived threat.
- If a person is frustrated, staff speech patterns should be quiet, firm, low and repetitive. Use the broken record technique. It takes practice but it does work.
- Avoid communication that demonstrates loss of control. This only increases the chance that a person will become physical.

De-escalation techniques with an intimidating person

- involve speech patterns that are matter-of-fact, emotionless (as flat an affect as possible), with clear, direct statements of consequences.
- Your speech should not be condescending or sarcastic.

Considerations

- Personal space and body language communicate much of how we feel. Personal space refers to our comfort zone. This individual preference must be respected.
- Touch is not a good way to comfort a distressed person. Most people want space. The only exception may be if the person is crying. Take cues from their facial expressions as well as their hand gestures, the way they approach, their size and appearance.

- Your body language sends messages as well. Have an open stance. This lets people know you are listening.
- If someone is agitated, be aware of your own safety. Have your hands free and at your sides. Stand at an angle, not facing the person straight on. Stand with one foot back and your knees slightly bent.

Strategies to Avoid Physical Harm

- Safety First
- Intervene early at the first signs of escalation. Don't think that if you ignore them they'll go away!
- Keep others away from angry people.
- Alert staff members and security guards to be close by.
- Avoid appearing to gang up on someone, but if necessary, a show of numbers usually fosters compliance.
- Only one person should verbally direct the agitated person. However, additional staff provide support by their presence.
- Allow angry people time and space.
- Remember "fight or flight," and allow them a graceful way out.
- Train staff members how to manage assaults for times when physical containment is required.
- ***Realize that people with frightening hallucinations, paranoid delusions, and/or who are under the influence of substances, usually are not receptive to verbal de-escalation. Medication and special interventions may be required.***

Physical Maneuvers to Diffuse and Avoid Violent Behavior

Physical maneuvers are used as the last resort and only when all tactics have failed. Never plan to fight an attacker and win; do only what it takes to get away from them.

Guidelines to avoid the need for Physical Maneuvers

Mental Preparation - Get rid to the irritations and triggers from home prior to working with the clients. Physical preparation includes situational awareness, keeping yourself prepared, and mobile.

Situational awareness is developed by good observation skills. What do you notice about the people you work with? How well can you spot changes? Where do you place yourself to make your observations? Do you communicate what you observe to other staff in a timely fashion?

Ready for action. Keep yourself on the balls of your feet ready to move.

Keep an eye on your surroundings. Do not get yourself in a situation with no escape possible. Keep your hands free, not in your pockets. Do not sit down without the notion of how to get up quickly.

Have your body ready to move. You need to do some stretching exercises prior to getting on the floor. Limber your neck, shoulders, torso and legs. Practice balance by standing on your toes first with both feet and then one foot at a time. Increase flexibility by toe touches. You must be prepared.

If a person is threatening, start crisis communication and evade.

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Evasion Techniques

Problem	Technique
Biting	Move towards the bite.
Caught in a bear hug	Push upward on the person’s wrist. Move downward to try to get out of the hold.
Choked	If you're attacker has their hands around your neck do not try to pull them away at the hands (as your instincts would lead you to do) instead put your arms in between their arms and with as much strength as you can muster hit out their elbows, at the same time turn your body and head in your strongest direction (left if you are left handed, right if you are right handed).
Grab	Find the weakest part, for example, between the thumb and the first finger. Pull up or down at the weakest point.
Hair Pull	Move towards the person. Place both your hands on the person’s knuckles to flatten the hand. Bend forward, move back, and turn away in circles.
Head on Charges	Get out of the way, move in circles
Kicks	Get out of the way, move in circles
Pinching	Flatten hand against your body. Move towards the person.
Punches	Get out of the way, block with your hands.
Scratching	Move towards the person.

Restraining Techniques

Escorting and Containment Techniques

Problem	Technique
Standing Restraint	Two persons on either side of the client, facing the same direction. Hold client’s arms, then bend forward.
Escort	Client is standing upright. On staff person on each wrist walking on either side.
Floor Restraints	Require 5 persons. Not recommended as they place the person in a prone position. Especially not recommended for elderly persons.

Appropriate Use of Medications as Chemical Restraints

Medications are also considered a form of restraint. If a client's behavior requires and intervention with drugs, the same protocols utilized for physical restraints apply. Understanding various terms and how they are utilized is important.

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Seclusion is defined as:

The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.

Restraint is defined as:

Any manual method or physical or mechanical device, material or equipment attached or adjacent to the client's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

Chemical restraint is defined as:

A medication used to control behavior or to restrict the client's freedom of movement and is not a standard treatment for the client's medical or psychological condition.

The standard of use for seclusion and restraints are: (these are general guidelines that may or may not apply to your facility or state).

- Emergency situations if needed to ensure the client's physical safety less restrictive interventions have been determined to be ineffective in least restrictive manner and with safe techniques end at earliest possible time

- Physician or Independent Licensed Practitioner ordered. Treating physician must be consulted as soon as possible (if did not order use).

- Can not be a PRN order

- Time limits:
    - Written orders; 4 hours for adults- 2 hours for ages 9-17 and 1 hour for under age 9.
    - May be renewed up to 24 hours.

- In- Person evaluation of client:

- Physician or Independent Licensed Practitioner must see and evaluate the need for use within 1 hour after initiation.

- If client is no longer in restraints at end of verbal order the physician or independent licensed practitioner must still see and evaluate the client within one hour.
- The client must continuously monitored. The client must be physically checked every 15 minutes.

- Time out is a behavioral consequence written in the client's Individual Program Plan (IPP) used to remove the client from reinforcement opportunities in the environment.

- Clients' right to avoid restraint: this is actually two different standards, one that applies to acute medical and surgical care, and another that applies to behavior management.

- Acute medical and surgical care: restraint includes physical restraint and drugs used to restrain.

- Restraint can only be used when less restrictive interventions have been determined to be ineffective.

Chemical Restraint Guidelines

1. Sedative agents may be used to provide a safe, humane method of restraining the violently combative client who presents a danger to themselves or others and to prevent the violently combative client from further injury while secured by physical restraints

2. These clients may include but are not limited to the following:
- Alcohol and or drug-intoxicated clients
- Restless, combative head-injury clients
- Mental illness clients
- Physical abuse clients (more humane than physical restraint)

Chemical Restraint Suggested Procedures

1. Assess the possibility of using physical restraint first; evaluate the personnel needed to safely attempt to restrain the client

2. Have sedative medication prepared for injection; prepare for possible hypotensive side effects

3. Contact Physician prior to administration and clearly state the need for sedation if you think it is necessary for safety or client care

4. Administer medication as ordered.

- Vital signs should be assessed within the first five minutes and thereafter as appropriate
- Haldol is often the drug of choice.
- If necessary, contact the Physician for additional sedation.

5. Assess the need for sedation carefully
- The violently combative client stands a lesser chance of injury when sedated
- Clients who are physically restrained and aggressively fighting their restraints and head injury clients who are combative and compromising their airway and C-spine may be candidates for sedation
- Chemical restraint precautions: Side effects of Haldol may include hypotension, tachycardia, and acute dystonic reactions. Treat symptoms of dystonic reaction with Benadryl as ordered. Watch for increased sedation

Employee Resources and Incident Debriefing

Post Incident
- Review the incident with the team.
  - Discuss the incident
  - Meet in a quiet place
- Perform a debriefing with the client.
  - Assess safety
  - Discuss the triggering event
  - Look for a pattern
- Try to determine what could have been done differently.

- Discuss with your manager or human resources if you need additional assistance such as employee assistance.

Complete an Incident Report

Document the event completely:

Documentation of the event is the legal record. It is important to be clear and accurate in the documentation. You must use words and descriptions within your scope of practice. After an assaultive episode, you must recover, relax and re-gain your thinking ability. Talk to the other staff and get an accurate account of the episode. Documentation must include what part of the care plan didn't work and what "plan B's" were attempted. The documentation will describe the event and then what was finally done to return the client to the primary treatment plan.

If you ever have to give a deposition or go to court about an assaultive event, your documentation is the legal record of it. If asked what happened during the episode, read your documentation. Do not rely on memory. Documentation will demonstrate your efforts at preserving the client's civil rights.

1. In what manner was your client violent? Record client's comments verbatim.
2. Did you feel threatened? Why?
3. Were you concerned about your client's outcome without emergency medical interventions? Why?
4. Could you treat your client appropriately without the use of restraints?
5. What Law Enforcement Officer was present?
6. What physician provided the order? Who was on-line medical control?
7. Document the frequency of respiratory and mental status change assessments. *
8. If your client was physically restrained, was he prone or supine?
9. What kind of restraints did you use?
10. Where on your client were these restraints placed?

Constant evaluation of your client's airway status and documentation of such is extremely important.

Those who work in the healthcare industry are in situation were clients and families are stressed, impaired or frightened. These situations place workers at risk for assaultive situations. Early detection of behaviors, utilization of verbal de-escalation techniques can help avoid harm to the client or the healthcare professional.

ASSAULT RESPONSE TRAINING COMPETENCY ASSESSMENT

May be used to add a competency to the self-study module learning.

Name_______________________________________ **Title** ____________________

(Please Print)

I have completed the skills that apply:____________________________________

Employee Signature

Employee has completed skills: _______________________________

Manager or Educator Signature

Method of Observation: E=Exam O=Observation V=Verbal Response R=Return Demo

CRITICAL ELEMENTS	METHOD OF OBSERVATION	INSTRUCTOR INITIALS
DEPARTMENT SPECIFIC COMPETENCIES		
1. Events Leading to Escalation	***Date Observed:***	
a. Is able to verbalize 2 situations that place client's at risk for aggressive behavior.	V	
b. Is able to verbalize a situation where aggressive behavior may occur without warning.	V	
c. Is able to describe 2 client behaviors that may indicate escalation of behavior.	V	
2. Verbal De-Escalation Techniques	***Date Observed:***	
a. Given a scenario, is able to utilize 2 techniques to help de-escalate behavior.	O	
b. Is able to verbalize two factors which may place the healthcare worker at risk.	V	
c. Is able to verbalize two safety measures when working with potentially escalative clients.	V	
3. Hand-On Techniques	***Date Observed:***	
a. Is able to demonstrate the technique to evade a choke hold (without hurting the client)	R	
b. Is able to demonstrate a safe release of a grab of the arm.	R	
c. Is able to demonstrate safe release of a hair pull.	R	

References

Topic	Reference
Assault – Teen Advice	http://teenadvice.about.com/library/weekly/aa121302c.htm
Assault Cycle	www.violenceprediction.com/images/assault_cyc.gif
Assault Response	Mt. San Antonio College Psychiatric Technician Program Handout
Crisis Model Caplan	www.gp-training.netwww.gp-training.http://images.google.com/imgres?imgurl=http://www.gp-training.net/training/mentoring/caplanwww.gp-training.net
De-escalation techniques	http://66.102.7.104/search?q=cache:wS-ogftpHikJ:web.missouri.edu/~projlife/wint02.pdf+verbal+de+escalation&hl=en
De-escalation techniques	http://tidewater.vaems.org/protocols/2003%20Protocols/Appendix%20D%20Client%20Restraint.pdf
Emergency Room Violence	http://jackiespeier2006.com/meet_the_candidate/legislation/health_care.html
EMS Defensive Tactics:	http://www.tdh.state.tx.us/hcqs/ems/SODefensive.htm
Escalating Limiting Language	http://www.beyondintractability.org/m/escalation-limiting_language.jsp
Evasive Techniques	http://66.102.7.104/search?q=cache:53VVCOiZQIMJ:www.tcc.fl.edu/dept/ptlea/forms/cjstc6_defensive.pdf+EVASIVE+TECHNIQUES,+ASSAULT&hl=en
Handling Angry Clients And Families	http://guidancechannel.com/default.aspx?index=999%20&cat=22 By Unknown Unknown for Wellness Reproductions & Publishing, LLC
Client restraint	http://www.charlydmiller.com/RA/alltiedup1.html
Self Defense	http://www.nononsenseselfdefense.com/psychology.html
Verbal de escalation	http://www.vanderbiltlearningcenter.org/leadership/uploads/50
Verbal De-escalation	http://siri.uvm.edu/ppt/verbal/tsld002.htm

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References also from Harrison's 14 CD Rom, McGraw-Hill.

This is the end of the module: Please complete the evaluation and answer sheet