Beth Israel Lahey Health
Anna Jaques Hospital

Compassion in Care Training

Instructor Manual

Anna Jaques Hospital

Newburyport, MA

Training Objectives

We work with people in varying states of pain, fear, uncertainly, resistance and anger. Our goal is to apply therapeutic interventions with our patients so that treatment can occur in a mutually respectful and safe environment by:

- Understanding the motivation for behavior
- Learning effective communication skills
- Developing effective de-escalation techniques
- Utilizing behavior plans
- Training in situational awareness
- Practicing self – defense skills
- Working as a team in the management of violent behaviors

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Unit 1: Using Knowledge & Skills to Achieve Positive Outcomes

A. UNDERSTANDING BEHAVIOR (WHY PEOPLE DO WHAT THEY DO)

Behavior is defined as "a particular way of acting" (Cambridge Academic Content Dictionary), or "the way in which one acts or conducts oneself, especially towards others," and "Anything that an organism does involving action and response to stimulation" (Merriam, Webster).

What affects how we behave?

• Our histories and experiences • Personal abilities & capacities • Intellectual capacities • Race & Culture • Personal beliefs • Our personalities • What we witnessed (and learned to imitate) growing up (events, family coping skills) • Sense of right and wrong	• Autopilot reactions (conscious & unconscious) • Effective coping skills • What we perceive as nonverbal messages • What we perceive as threats • Expectations • Our stage of life • Current emotions

Experiencing physical and emotional pain lowers our frustration tolerance considerably. Our pain becomes the center of our attention."
(Hendricks)

Medical conditions also can influence behavior and how we think and process.

What do we see in the hospital setting that affects behavior?

- **Hunger, thirst, pain or fatigue can lead to irritation and impatience, and difficulty processing**
- **Abnormal oxygen and blood sugar levels can alter ability to mentally process**
- **Drug and/or alcohol use, and/or detoxing can alter processing, sensory input and interpretation of surroundings/actions/communication**
- **New information – frightening information, diagnoses**
- **Physical Impairments/limitations can increase a sense of vulnerability, frustration, not having needs met**

"**Given that adults are generally used to making decisions for themselves, offering them a range of options enables them to take an active part in solving the problem or, at least, reducing their feelings of anger.**"

("De-escalating Anger")

B. THE PHYSIOLOGY OF EMOTION

The brain is affected first.

Strong emotions (pain, anger, fear, extreme anxiety) have associated physiological reactions, such as:

- **Unconscious tensing of muscles, especially face and neck**
- **Sweating, feeling hot or cold**
- **Shaking of the hands, legs**
- **Facial paling or redness, visible veins due to increase in blood pressure**
- **Dramatic increase in breathing rate, heart rate, blood pressure**
- **Release of adrenaline creating a power surge**
- **Increased sensory perception**

During a de-escalation attempt it is valuable to recognize when a patient is operating under the:

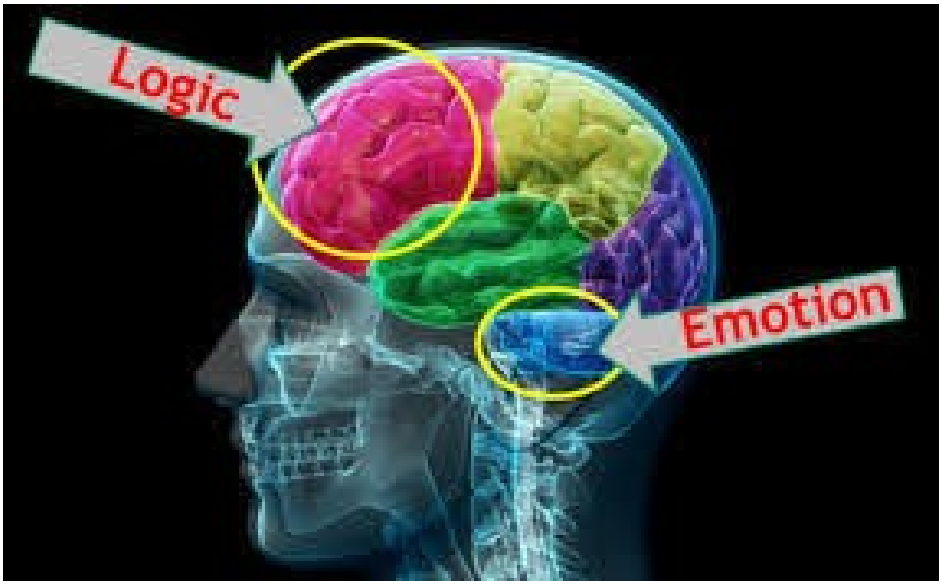
(1) **parasympathetic** (still has the ability to process) system, or

(2) **sympathetic** response (freeze, fight or flight), as the difference determines their ability to listen, process, and negotiate. Neurotransmitter chemicals released in the brain cause a burst of energy that can take several minutes to abate, meaning the patient cannot "calm down" immediately when we tell them to.

An observant, mindful, goal-focused communication can mean the difference between de-escalating and exacerbating a conflict.

A professional, caring, informed response can help calm, and redirect the patient's response.

Additionally, our ability to manage our emotional responses will impact outcomes.



Bodily responses to fear can be detrimental, especially since the most important one is a negative one: the brain basically shuts down as the body prepares for action. The cerebral cortex, the brain's center for reasoning and judgment, is the area that becomes impaired when the amygdala senses fear. The ability to think and reason decreases as time goes on, so thinking about the next best move in a crisis can be a hard thing to do. Some people even experience feelings of time slowing down, tunnel vision, or feeling like what is happening is not real. These dissociative symptoms can make it hard to stay grounded and logical in a dangerous situation. (Call)

C. EFFECTIVE COMMUNICATION (USE DEMONSTRATION OF INTERVIEW)

Exercise: Effective Staff – Patient Interview

Key points to effective and therapeutic communication:

- **Active listening**
- **Validation**
- **Using open – ended questions**
- **Unconditional positive regard**
- **Being genuine**
- **Aligning Goals and Objectives**
- **Consistency**
- **Motivational Interviewing / Communication Style**
- **Avoiding power struggles**
- **Mirroring behaviors**

DEFINITIONS / EXAMPLES:

- **Active listening** – **Giving a conversation your full attention through verbal and nonverbal cues, listening to achieve comprehension, communicating that understanding.**
- **Validation** –**Affirmation that a person and their feelings are valid. You do not need to agree, they do not need to be right. Meet them where they are, not minimizing, not negating ("I see that you feel very uncomfortable" vs. "you're not scoring, so you can't really feel that bad").**
- **Using open – ended questions** - **("What do you need the most right now?").**
- **Unconditional positive regard** - **(Does anyone enjoy feeling negatively judged?).**

DEFINITIONS / EXAMPLES (cont.):

- **Being genuine** – **"…nurse's genuineness is determined through the level of consistency displayed between their verbal and non – verbal behavior" (Ahern).**
- **Aligning Goals and Objectives** – **Moving to a common goal. Helping the patient accept that there may not be the resolution they want, but you are trying to meet them part way. ("We are not ready to discharge you, is there anyone that you would like to call right now who could come sit with you?").**
- **Consistency** – **When we are inconsistent in our responses and answers, we cause frustration for the patient, and set up each other for a conflict. (Sorry, the bathroom door cannot be closed." "You can close the door, but just for 5 minutes.").**
- **Motivational Interviewing Communication Style** – **goal is to motivate patient to make choices that encourage cooperation and aligning our goals, reducing resistance, and increasing insight.**
- **Avoiding power struggles** – **we are in the position of authority and control. Offering choice, giving the patient some control helps to minimize the frustration of having your control removed.**
- **Mirroring behavior** - **shifting emotional energy by leading the patient with our movements and body language.**

Building rapport and trust means using eye contact, patient's name, being honest, respectful, and nonjudgmental, being aware of nonverbals and paraverbals, going the extra mile: the little things matter!

Successful de-escalation also requires our ability to regulate our own stress level and presentation.

IF we project a belief that this situation can be resolved calmly, we may be right.

- **Emotions are contagious - People tend to mirror the emotions they are presented with**
- **Be proactive and prepared. Know what frightens or angers us, and why, and how to manage.**
- **It's not about you. Recognize when our ego has been engaged, and practice letting go.**
- **Get supervision after a disturbing event – avoid carrying reactions from situation to situation**
- **Notice personal bias – are we/they judging before we begin interacting? Practice letting go of how that may influence our response.**
- **Remember why you entered this field – to help**

"The cause of anger is almost always an unmet need….."
(De-escalating anger)

Exercise: Create lines facing each other

The non-verbal messages: 50 – 85% of communication is non-verbal.

What is it that you are actually saying? (Use demonstration of 2 lines and personal space needs under different circumstances)

- **Proxemics** awareness of personal space communicates respect vs. disrespect, acknowledges safety vs. risk, initiates the interaction on a strong footing
- **Kinesics** body language communicates attention vs. disregard, safety vs. threats, focus vs. distraction
- **Speech** tone, speed, inflection communicate interest vs. disinterest/impatience, focus vs. distraction, safety vs. threat

Does your non-verbal message help or hinder a safe resolution?

First impressions strongly influence the patient's willingness to engage with us.

D. USING MINDFULLNESS TO IMPROVE COMMUNICATION

"Between stimulus and response, there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom."
-Victor Frankl, M.D. (holocaust survivor)

What is Mindfulness?

Mindfulness can be described as the practice of paying attention in the present moment, and doing it intentionally and nonjudgmentally. What this can accomplish:

- **Conveys respect and attention**
- **Reduces stress for all parties**
- **Increased focus for all parties**
- **Improved emotion regulation for all parties**
- **Increase empathy for our speaker when we truly listen**
- **Improves the chances of hearing the real message, the "unmet need"**

"Within the practice of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them, and without reacting to them in an automatic, habitual pattern of reactivity. This introduces a 'space' between one's perceptions and one's responses. In this way, mindfulness practices help us to respond reflectively to situations instead of reacting to them based on conditioned habits or reflexes"

(What is)

E. TRAUMA – INFORMED CARE: UNDERSTANDING, RECOGNIZING, AND RESPONDING TO CREATE A POSITIVE OUTCOME

"Hurt people hurt people"

People with a trauma history (emotional, physical or sexual abuse, or participants/witnesses to traumatic events) experience changes in their brain in ways that affect their response to what they perceive as triggers/threats.

Their reactions may be different from those without PTSD, and they have limited control over them. These sensitivities are something we need to acknowledge if our goal is to facilitate the therapeutic management of a stressful moment.

Post-Traumatic Responses are shaped by the 5 P's:

- **Past experiences -at, home, as a child, in a hospital. The more horrific and enduring, the more likelihood of PTSD**
- **Personality – introverted, extraverted, submissive, defensive?**
- **Perception of situation – am I at risk? Is this causing me to feel shame?**
- **Precipitating factors –the look, the voice, the tone, the weather, the internal feeling– am I triggered?**
- **Preferences – am I more comfortable around women? Was I abused by a woman? Was I bullied in school, do I feel I am being bullied again? Do you look like my abusive uncle?**

"PTSD is not a disorder, it is a natural reaction to an unnatural event"

unknown

"Brain scan research shows that, when we remember a traumatic event, memory centers in the frontal lobes shut down, and we get overwhelmed by feelings and impulses instead of recalling events. "Trauma survivors have symptoms instead of memories."

(Fisher)

Post-Traumatic Stress Disorder Responses include:

• Overwhelming emotions • Exaggerated startle reflex • Hypervigilance/mistrust • Substance abuse as a coping skill • Eating disorders • Self-destructive behaviors	• Shame & worthlessness • Irritability • Guilt • Decreased concentration • Insomnia • Disassociation

"We remember trauma with our feelings and our bodies."
(Fisher)

F. TRIGGERS

Google the word "trigger"

trig·ger /'trigər/ **trigger**; plural noun: **triggers**
noun:

1. a small device that releases a spring or catch and so sets off a mechanism

verb:

1. cause (an event or situation) to happen or exist
   "Something that causes someone to feel upset and frightened because they are made to remember something bad that has happened in the past"

A trigger is a reminder of past experience or trauma, and can elicit specific emotion and even flashbacks.

- **Can be a person or a thing**
- **Something seen, heard, felt, smelled, touched, tasted**
- **Something that we have no awareness of (burned with cigarette butts as child, panics when smells cigarettes)**
- **Sparks a response that may appear out of context to the situation**
- **Knowledge of triggers helps to understand/avoid causing an increase in stress/fear/anger**
- **Being aware that triggers exist can help with our questioning and support when a reaction seems out of context**

How will we know about a patient's triggers?

ASK

Using this knowledge can affect the outcomes of our interactions.

G. BEHAVIOR PLANS

For patients with challenging behaviors, consistently in care is critical to avoiding confrontations.

Behavior plans provide individually crafted blueprints to identify triggers and interventions, outline failure consequences, and define expectations for patient and staff.

Treatment **NEGOTIATED** with the patient provides a mutually agreed upon and understood direction, providing:

- **Clear goals & direction**
- **Clarification of treatment, staff responses, patient expectations**
- **Proactive redirection for negative behaviors**
- **Consistency for staff actions and messages across shifts**
- **A growing bank of information and successful interventions for this particular patient in learning to manage negative stress without losing control**

Behavior Plans AVOID "reinventing the wheel" every time there are new staff, and avoid continued, repetitive conflict

Summary of Suggestions for Resolving Conflict:

- Listen for the unmet need, the root of the conflict
- Remember what you know about trauma, about diagnoses, about brain activity during stressful times
- Strive to ignore the challenging behavior
- Active listening means active listening
- Present a calm, professional, optimistic, compassionate listener
- Be attentive you your own emotional reactions – understanding allows control
- Strive to find a common ground – Review options to find common ground.
- What compromise can we make?
- Respect space
- Isolate the situation if you can, but don't put yourself alone and in danger
- Remember the whole person view: they have strengths and challenges, families and loved ones, plans and goals.
- Use silence and redirection, and refocus on the goal.
- Use the broken record approach, "how can I help you?"
- Reality testing re: choices and consequences
- Paraverbals say more than your spoken word – what are you <u>really</u> communicating?
- Using physical movement to help the patient calm- walk with them

H. SPECIFIC DIAGNOSES, PRESENTATIONS & INTERVENTIONS

Knowing the basics of common psychiatric and organic diagnoses can improve our communication, and avoid or diminish confrontations.

PRESENTATION	*INTERVENTIONS*
ANXIETY *Can be situational, chemical, biochemical*	
• Anxious, fearful, panicky • Shortness of breath • C/O chest pain/discomfort/racing heartbeat, nausea • Trembling, sweating • Numbness/tingling • Feeling of being detached/physically and/or emotionally numb	• Kindness • Compassionate support • Non-judgmental listening • Anti-anxiety medications • Sensory tools: weighted blankets, warmed blankets, hand manipulators, sound machines, etc • Ask the patient if they practice an intervention that is successful
DEPRESSION/SUICIDAL *For some, the pain of living can outweigh the pain of dying*	
• Flat, blunted, sad affect • Appetite and sleep changes • Diminished ability to think or concentrate • Risk of harm to self with: o Thoughts o Thoughts with plan but no intent o Thoughts with plan and strong intent o Thoughts with plan and intent and attempt	• Non-judgmental listening (reminders they are not alone) • Compassionate support • Sensory tools • The "little things:" o cold drink, hot tea o warm blanket o Kindness
ADDICTION & SUBSTANCE ABUSE *Alcohol and drug use can serve as a coping skill; however maladaptive it may be.*	
A. SEDATING SUBSTANCES *(sedatives, hypnotics, anxiolytics, alcohol)* During intoxication: drowsy, lethargic. During withdrawal: Anxious, irritable, easily angered, belligerence, threatening	• Minimize number of staff interacting • Minimize external stimulation • Attitude: professional, calm, avoid communicating judgement • Communicate clearly & slowly • Don't try to rationalize with someone when under the influence. • Positive wording – ("I want to help you through this") • Humor can help or backfire • Staff can withdraw at times with verbalized plan to return – may help with impasses

B. **STIMULATING SUBSTANCES** ***(amphetamines, cocaine)*** Psychotic symptoms, anxiety, with depressive symptoms during withdrawal.	• Distraction • Using stable family and friends to help calm • When sober: identify the behavior, ("you appear to be craving/needing to use. We want to help")

PERSONALITY DISORDERS *Collections of personality traits that have become rigid and work to an individuals' disadvantage, impairing functioning. Affects how people and events are interpreted*	
Paranoid	
• Withdrawn, suspicious or irrational. • Quick to take offense. • Can appear peculiar, eccentric.	• Identify actions/words that may be associated with increasing suspiciousness. • Minimize words. • Communicate clearly and professionally. • Medication
Antisocial, Borderline, Histrionic, Narcissistic	
• Theatrical / emotional. • Attention-seeking. • Labile in moods. • Interpersonal conflicts	• Nonjudgmental interactions. • Remaining professional. • reassurance. • Practice careful boundaries. • Consistency among staff. • Focus on the moment.
Avoidant, Dependent, Obsessive-compulsive	
• Anxious & tense. • Over controlled • Rigid	• Reassurance • Concise information • Clear communication
MANIA	
• Possibly inappropriate dress: revealing, or wrong for season/temperature • Hyperverbal • Grandiosity • Lack of judgement • Lack of sleep • Impulsive • Irritable, easily angered • Flight of ideas	• Decreasing the stimulation • Low lighting, low noise. • Mood-stabilizing medication • Channel their energy in whatever way you can. • One focus at a time. • They are desperate for sleep • Medication.

<table>
<tr><th colspan="2">PSYCHOSIS</th></tr>
<tr><td>• Possibly inappropriate dress: Disheveled, wrong for season/temperature
• Bizarre, disconnected responses
• Hallucinations
• Paranoid, fearful, visibly frightened or angry.</td><td>• Ensure a sense of safety
• ask the patient what will help.
• Kindness
• Build trust
• Evaluate their ability to comprehend
• Medications
• Watch their non-verbal clues

Is there anyone that they trust that can be helpful in encouraging cooperation, especially with medication?</td></tr>
<tr><td colspan="2">AUTISM
A neurodevelopmental disorder characterized by persistent difficult in social communication and social interaction, coupled with restricted and repetitive patterns of behavior or interest" Fitzpatrick et. Al)</td></tr>
<tr><td>Difficulty:
• Reading social cues, understanding others' intentions
• Putting feelings in words
• Tolerating environmental stimuli (activity, noise, bright lights, physical touch).
• Feeling empathy, displaying social skills
• Managing emotions/moods
Demonstrates:
• Ritualistic or compulsive behavioral patterns.
• Limited behavioral flexibility/rule governed.
• Makes little to no eye contact.</td><td>• Stay simple – yes or no questions when possible
• Use concrete, literal words. Avoid abstract.
• Allow extra time for processing
• Reduce the level of environmental stimuli however possible (reduce wait times and minimize activity/traffic/noise/bright lights).
• Ask family / caregivers for best techniques that are helpful for the patient.
• Quickly establish the best mode of communication for patient (verbal/written/pictures, use of behavioral technology).</td></tr>
<tr><td colspan="2">DEMENTIA
(a broad term loosely covering many neurocognitive disorders – the core features are declining cognitive functioning)</td></tr>
<tr><td>• Increased difficulty in environments with multiple stimuli
• Easily distracted
• Increased effort to complete tasks
• Repetitive in conversation
• Impaired memory
• Verbal outbursts and violence</td><td>• Evaluate and assist with basic functions; eating, dressing, toileting, ambulation
• Folding, organizational tasks
• Looking at books or newspaper
• Music, TV
• Simple puzzles
• Social interaction</td></tr>
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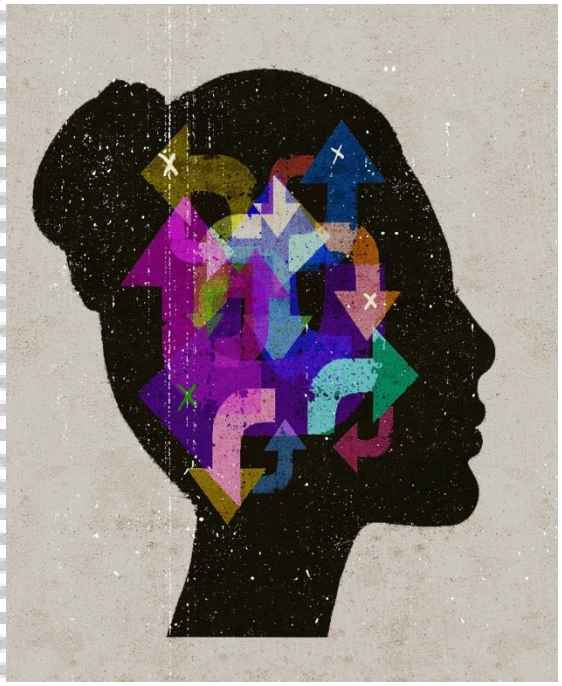
BRAIN INJURED	
• Difficulty finding the right words. • Short term memory deficits. • Changes in mood, apathy, confusion. • Difficulty completing normal tasks. • Repetitive, struggles with change. • Decreased motor skills. • Decreased problem solving. • Impulsivity. • Concrete thought patterns	• Offer help respectfully. • Praise. • Anticipate more time to complete requests. • Use visual activities. • Ask about preferred activities. • Patience • Consistency as much as possible.



Unit 2: Personal Safety – Stay Safe, Get Help!

At times, your very best work will not avoid a physical confrontation. This unit involves keeping yourself safe and getting out of danger

A. SITUATIONAL AWARENESS

- Be your strongest self: Stand, breathe, put your mind in your center, and feel your feet
- Develop an awareness of your surroundings so you can recognize potential for risk before it becomes a dangerous situation
- Know your exits and identify possible obstructions to exiting
- What could be used as a weapon? Pens, cords, hot fluid, etc.
- Are there visitors in the room? Don't assume they cannot be a danger to you
- When entering a room, greet the patient and be attentive to the response
- Find a second staff member to support you if you feel uncomfortable
- Do not ignore threats, verbal or nonverbal

Exercise: Set up a room, look at furniture placement, barriers, doors, act out scenarios that would be risky, getting trapped in the room, etc. Review the Safe Room checklist

Warm-Ups (10 minutes)

- **Basic stretches and warm ups**

B. PERSONAL AWARENESS: Moving and Maintaining Safe Zones

Safe

Less-Safe

Risky

Be in your body and maintain situational awareness

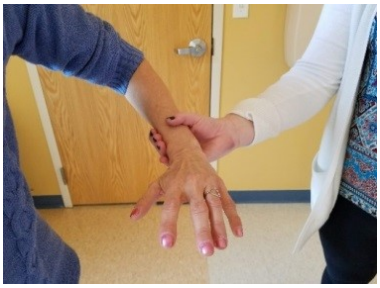
- "Skating" past a potential threat.
  - Step outside, same side, same foot.
  - Step forward on outside foot and to the outside

Exercise: "skating" footwork and evading "sharks"

- **Practice in pairs to ensure students are comfortable with the movement**
- **Designate 2 – 3 sharks, preferably trainers, who will intentionally walk towards participants**

C. MANAGING A WRIST GRAB

Weakest part of grab is between the patient's thumb and forefinger.



1. One-handed grab – same side

- Counter-grab with free hand
- Elbow moves forward, level, thumb towards belly button
- Get away

2. Two-handed grab

- Counter-grab patient's cross hand with thumb on top
- Same release as one-handed grab – same side

Two-handed grab

Counter grab cross wrist

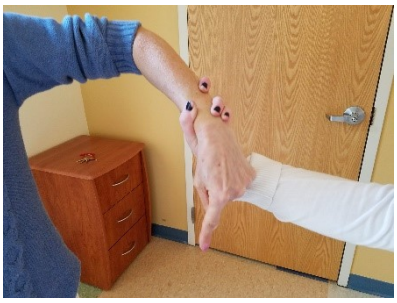
Free hand and move past

3. <u>One-handed grab – cross hand</u>

- "Rainbow" escape – follow index finger up (inside), over, and down
- Get away

Up to the inside

Over



Down to the outside

D. <u>MANAGING A CLOTHING GRAB</u>

- Counter-grab patient's cross hand with your thumb on the base of her thumb while keeping your elbow down/against your body
- Turn your hips over and get away

Exercise: Repetition of same moves, then getting to the door with grabs occurring

E. MANAGING A STRIKE

1. When you feel threatened:

- Hands out and back up
- Use your voice: "Stop!", "Staff!" or "Team Control!"
- Keep good posture to show confidence

2. Attempted Strike:

- Outside hand (away from patient) reaches out to "brush" patient's wrist/forearm off the line of attack
- Pass to the outside maintaining control, using cross/back hand behind patient's elbow

Brush forearm away with outside hand

Reach under with inside hand and pass

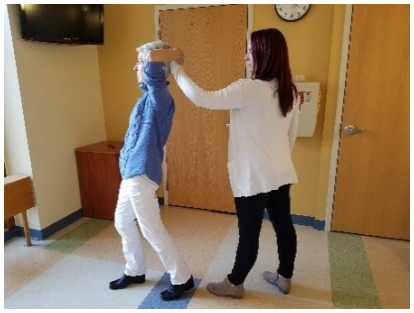
Exercise:

- **Paddycakes**
- **"Frankenstein" walk**
- **Get to the door with grabs and strikes**

F. MANAGING A HAIR GRAB FROM BEHIND

1. Hair grab – short hair, both hands

- Counter-grab and secure/press patient's hand into your head
- Drop your center, getting your hips under your head
- Turn inward to face patient
- Drive patient back – if you break free, get away
- If you cannot break free, yell and continue to hold the grab



Secure hand to head

Drop hips under your head

Turn in and push away

2. Hair grab – ponytail (*best practice – keep your hair in a braid/bun!)*

- Grab your own hair above the patient's hand to reduce pull on your hair
- Same as above with short hair grab

Counter-grab patient's hand

Drop hips under your head

Drive towards patient

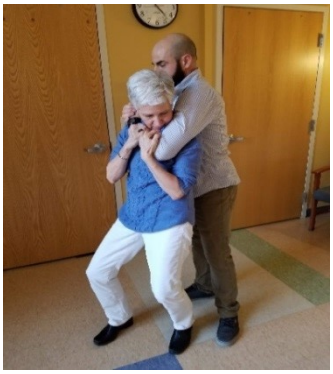
G. MANAGING A CHOKE FROM THE FRONT

- Drop chin to protect airway
- Raise one arm straight in the air
- Step back and away, and drop elbow down on top of attacker's forearms
- Counter grab attacker's cross hand (as in clothing grab escape) and pivot hips back to turn attacker away from you
- Push away to escape
- Get to safety and call for help

H. MANAGING A CHOKE FROM THE BACK

Arm around the neck (Half Nelson Choke)

- Tuck your chin and turn your head so your nose is facing your patient's elbow to keep your airway open
- Grab the patient's forearm with both hands and pull your elbows down against your body
- Get your hips low, turn inward, and escape out the back



Turn chin to patient's elbow and pull down on forearm

Drop and turn inward

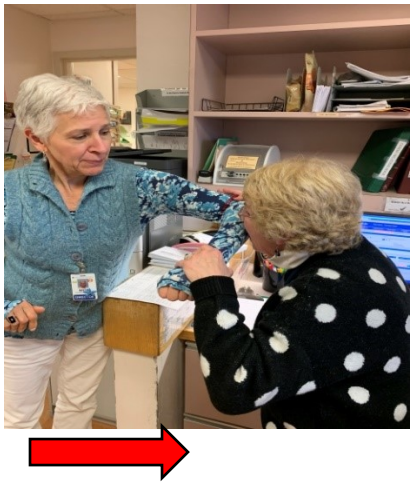
Escape

I. Escape from Bear Hug (rear)

- Drop hips and pull down on attacker's forearms to make yourself heavy and stable
- Find attacker's protruding hand/fist from below his arms
- Push his hand/fist out of the other hand that's securing his hold
- Pivot to face attacker and push away if needed
- Get to safety and call for help

J. MANAGING BITES

- Avoid the instinct to pull back, which could cause further damage to your flesh.
- Push into the bite
- Reach behind the patients head to pull them in



Unit 3: Managing an Out of Control Person with a Team

A. WORKING AS A TEAM

1. **What is a Team Control?**
   - **AJH terminology used to alert trained staff to provide support with a patient presenting a risk to themselves or others**
2. **How is a Team Control initiated?**
   - **Call 444, GIVE location**
   - **Anyone identifying a risk situation can call for a team, better safe than injured**
   - **Preparation:**
     - **Gloves**
     - **identify a Team Leader**
     - **share critical information**
     - **Remove potential weapons and risks (furniture, COWs, people)**
3. **Who is the Team Leader?**
   - **Someone who:**
     - **has a relationship with the patient**
     - **familiar with the precipitating events**
     - **experienced with this role**
     - **decides or assigns decision to use restraints**
4. **When does the decision to use restraints get made?**
   - **When the risk of NOT using restraints OUTWEIGHS the risk of the restraint**

For patients with a trauma history, there is tremendous potential for retraumatization with the use of restraint/seclusion

5. **Choosing the least restrictive approach**

- **Using negotiation to give the patient choices: can they cooperate without hands on? take a med and avoid mechanical restraints?**
- **What is the minimal amount of restraint required to assure safety?**

6. **The "show of force" (response by a trained Team Control)**

Pros	***Cons***
• **Sense of safety for staff** • **Patient will recognize the limits can and will be enforced** • **Patient may take the opportunity to rethink their response**	• **Can increase patient's agitation and fear** • **Can precipitate the conflict (you may be asked to stay out of sight)**

A Team Control called that does not result in hands on is a win for all

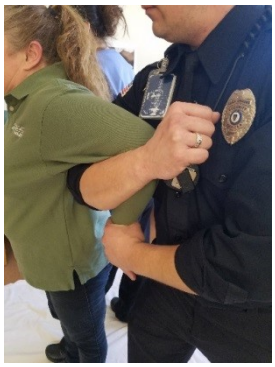
Socializing while you are waiting can also serve to undo the de-escalation work being done, particularly with a patient experiencing paranoia or extreme low self-worth ("I CAN HEAR THEM LAUGHING AT ME").

B. PATIENT ESCORT (using 2 staff to move patient with increased patient resistance)

1. **Position 1**
   - inside hand grabs thumb-up on patient forearm just above the elbow
   - Outside hand counter-grabs thumb-up at base of patient's wrist
2. **Position 2**
   - Outside hand maintains same grip as above, and inside hand rotates to thumb-down grabbing just above the patient's elbow
3. **Position 3**
   - Same as **Position** 1 & 2 above, but slip inside arm forward/inside to wrap up the patient's elbow/forearm, securing it against your body

Position 1

Position 2



Position 3

NOTE: distancing and body position are the best way to avoid injury. Your ideal position is to stand obliquely behind the patient at a 45-degree angle with your inside foot forward.

C. STANDING CONTROL POSITION – (taking control of a patient with 2 staff)

- Cut down and grab the patient's wrist.
- Grasp the upper arm (arm in bent position), thumb forward, and rotate arm/shoulder up and forward, elbow coming up, using this momentum to lever the patient forward

D. CONTROL OF A VIOLENT PATIENT

- Consider the physical constraints of the space:
  - Best angle of approach.
  - Objects that could be used as weapons.
- Team Leader initiates a plan and assigns responsibilities
- Communicate that you will be putting hands on for safety, not to injure
- Team Leader approaches the patient followed closely behind by a second staff
- Initiate contact and move into Standing Control Position on either side
- Both staff members will step forward with their inside foot.
- Bend the patient forward at the waist taking the patient forward and off balance, stepping forward to support the patient's weight.
- If the patient becomes compliant at this point, conversation can begin.

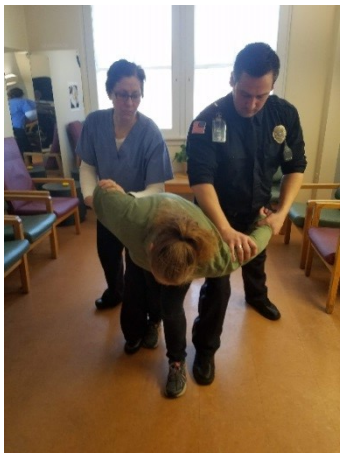
Leader makes initial contact

Leader moves to control position

Second staff member steps in

E. BRINGING AN AGGRESSIVE PATIENT TO THE FLOOR

- When patient remains noncompliant, Team Leader may decide to take the patient to the floor.
- The staff holding the arms will decide to go down to the left or right (depending on the space) so that both staff members know which side to move to.
- Both staff members will simultaneously shift their weight to the chosen side and bring the patient down to the ground.
- A designated staff protects the patient's face from hitting the ground or any objects.



Take patient forward

Shift weight to the side

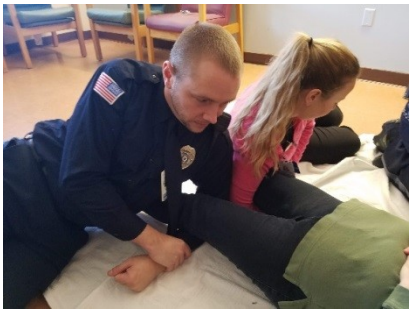
Carefully take patient to floor

When escorting or restraining someone, the less force you exert, the more energy you will save, the less panicked the patient will feel and the less likely they are to resist

F. RESTRAINING THE PATIENT ON THE FLOOR/STRETCHER

- **Compliant patient:** instruct her to place arms out in a "T" shape, and instruct them on transitioning to the bed/stretcher.
- **Non-compliant patient:** two staff members get down to a kneeling position and secure her arms out to the side.
- Each staff member in a kneeling position, placing themselves between the patient's arm and body
- Hold the patient's arm with one hand at the base of his wrist and the other above the elbow on the upper arm.
- Your thumbs facing inward toward each other and the patient's hand are palm-up.
- Spread your knees apart for a wider, more stable base
- Legs: Because the patient may be flailing or trying to kick, you will slide into position starting at the patient's hips facing his head and moving down the legs to just above the knees.

- Wrap your arm around the patient's legs as if you were applying a headlock, and counter-grab your own hand/wrist to further control the patient's legs.
- With 2 staff, manage one leg per staff



G. TRANSITIONING THE PATIENT TO A FACE-UP POSITION

There is risk in holding a patient on the floor face down (impaired breathing), the patient is turned face up ASAP.

Injury and death have occurred from:

- **Positional asphyxia, holds or compression impinging on the diaphragm and or ribs, such that respiration is impaired**
- **Use of the prone position**
- **Compression on patient's chest and or back**
- **Basket holds – when patient is bent over and compressed**
- **Patients with obesity**
- **Preexisting illnesses such as asthma, cardiac issues**
- **Aspiration**
- **Strangulation**

Optimum safety in restraint use requires*:*

- **Training and practice**
- **Correct application of restraints to patient and bed (practice)**
- **Staying with the training, Not introducing other techniques**
- **Continuous monitoring while restraints are in use**
- **Recognizing and responding to a change in patient status**

Secure arms in "T" position

Position arms overhead

Switch grips and roll

H. MOVING PATIENT FROM GROUND TO BED & APPLYING RESTRAINTS

- **Keep the patient informed of what is happening**

Optimum:

1 staff per limb, sheet to support middle

Lift patient as a team

Move patient onto bed

Applying restraints, check for 1 finger space

I. MODIFICATIONS FOR CHILDREN

- **Attacks from grabs:**
  - Same as with adults
  - be gentler with child's joints as they are weaker and more vulnerable to injury
- **Attacks from strikes/kicks:**
  - Same as with adults
  - kicks and punches from a smaller person will tend to come from below
  - brush and pass with your arm cutting down between you and the child's arm/leg, allowing you to get to his back side.
- **Restraining a child – Seatbelt hold:**
  - Move to the child's back and bend your legs so your chest is against their back
  - Reach your near arm under the child's near arm
  - reach your far arm over the child's far shoulder, and counter-grab your own hand
  - The child's arms and head/neck will still be free to move, so duck your head behind/against his upper back turning your head to the outside to minimize elbowing or head-butting to your face/head.

Keep one foot forward

Position head away from strikes

Unit 4: In Restraints: Patient Safety & Documentation

A. MONITORING THE PATIENT IN RESTRAINTS

- **Maintaining patient safety while in restraint requires*:***
  - Training and practice
  - Correct application of restraints to patient and bed
  - Continuous monitoring while restraints are in use
  - Recognizing and responding to a change in patient status

- **Immediately after applying restraints:**
  - **Put the head of bed up 30 degrees to promote respiratory action, and avoid asphyxiation if vomiting occurs.**
  - **Offer fluids immediately – they probably need it, and it is a comforting, respectful gesture**
  - **Monitoring skin and circulation for signs of too tight restraints: extremities getting blue or pale or cold, skin abrasion from thrashing**
  - **Continual monitoring occurs, watching for change in respirations, coloring, c/o pain, escape from restraint, etc.**
  - **Vital signs are checked while the patient is in restraints every 15 minutes, including for the first hour after a simple medication restraint to monitor the patient's physiological resonse**

B. DOCUMENTATION

- Know your department's documentation
- Objective detail – paint the picture

C. EVALUATION FOR RELEASE

- Are they physically fighting restraints or visibly calming?
- Are they swearing/threatening or calmly talking/sleepy?
- Do they demonstrate no insight or are they insightful, and willing to negotiate?
- Do they seem to be in tenuous control, or clearly has the crisis passed?

D. RELEASING

- Release one leg first and test patient's willingness to cooperate
- Opposite arm next, generally about 10-15 minutes later
- Final arm and leg together, again 10-15 minutes later
- Do not leave a patient in one-point restraint
- Releasing all at once is acceptable if safe and clinically indicated

Unit 5: It's Not Over When It's Over

A. DEBRIEFING

- **Is everyone physically ok?**
- **Is everyone emotionally ok?**
- **Was any part of the process in question?**
- **Did we learn anything that would be helpful with this patient in the future? (building the support plan)**
- **Saying Thank you to your team!!**
- **When do we do more formalized debriefing, and recommend EAP consideration?**
- **DMH licensed units: Patient Debriefing form to be offered within 24 hours, and a second time if refused, preferably by human rights officer not involved in event.**
- **This is a critical opportunity for change: Use for behavior plan/staff teaching/staff support.**
- **Valuable opportunity to learn ways to improve care and avoid further crises, and build the treatment plan.**

B. THIS TAKES A TOLL ON US (3 levels)

- **Compassion fatigue** – symptoms are visible, anxiety, depression, sleep issues, interpersonal issues at home and at work.
- **Secondary trauma** – actually triggered by work events, affecting your sense of safety, impeding your actual functioning.
- **Burnout** – lack of energy, motivation to go to work, or when at work, putting in less than 100%.

C. PRACTICING HEALTHY HABITS

- Working in healthcare, and with agitated, treatment-resistant patients at times requires a lot of focus and energy.
- We must practice self-care as part of our roles as health care providers.
- What are we doing to care for ourselves?
    - **Meditation**
    - **Reading affirmations**
    - **Exercise**
    - **Hydration**
    - **Whole health nutrition**
    - **Belief practices**
    - **Living and practicing your values**
    - **Structured routine: discipline, dedication and determination to care for yourself as a priority**
    - **Activities that feel good and are healthy: reading, hiking, being with friends, baking, etc.**
    - **EAP – using hospital services to process events**
    - **Asking for formal debriefing**
    - **Using ET time**

"Be the Change" Ghandi

Help us Grow – Suggestions?

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