



Kansas Hospital Association

De-escalation Webinar Series: "All Patients are Unique (Just Some More Than Others)"

De-escalation Techniques in Atypical Health Care Settings

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All Patients Are Special

(Just Some More Than Others)



De-escalation for Atypical Healthcare Settings

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Healthcare Security Challenges

Calming upset and emotional patients and visitors is a challenging proposition at any time, but in certain situations it can become much more complex based upon the patient populations that are being served.

In today's presentation we will examine some specialized patient populations and the unique circumstances involving their care that may require a closer review of how to de-escalate any conflicts that might occur.

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Special Patient Populations

Today we will review some challenging situations that healthcare care professionals can find themselves in regarding how to stay safe while verbally de-escalating others. The special situations that we will discuss today include:

1. Behavioral health patients (especially in emergency department / urgent care settings)
2. Dealing with forensic patients
3. De-escalation training for home health workers
4. Long term care residents and security concerns

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Review: What is De-escalation?

De-escalation, or soft self-defense, consists of verbal, psychological, and non-verbal techniques for diffusing potentially dangerous situations and preventing violence.

The goal of de-escalation is to build a rapid rapport with a would-be violent subject in order to reduce the likelihood of a physical confrontation and to calm the subject so that productive communication can occur.

De-escalation and conflict resolution techniques are vital to healthcare providers safety due to the overwhelming number of workplace violence incidents in the healthcare and social service settings.

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Review: What is De-escalation?

There are several non-verbal and verbal principles involved in de-escalating a situation when confronted with a potentially violent subject:

- Project a Calm and Confident Demeanor
- Treat the Other Person with Respect
- Use Proper Techniques When Speaking & Listening
- Determine the Level of Resistance
- Control the Encounter and Assume Proper Positioning
- Exit the Area and Get Help If Able to Do So
- Be Prepared to Defend Yourself If Required

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Behavioral Health Patients in Emergency Care Environments

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Trends Regarding Boarding of BH Patients in Emergency Departments

Data from the National Institute of Mental Health and from a Healthcare Cost and Utilization Project study* indicates levels of behavioral health issues in the U.S. are higher than most realize.

- In 2017, there were an estimated 46.6 million adults (18 older) in the U.S. with a mental, behavioral, or emotional disorder, representing 18.9 percent of all U.S. adults.
- Approximately one in eight visits to emergency departments (EDs) in the United States involves mental and substance use disorders*.

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*Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006–2013, H-CUP / AHRQ
<https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf>

Trends Regarding Boarding of BH Patients in Emergency Departments

- Compounding this issue, there is a severe shortage of psychiatric beds in the U.S. The number of public inpatient psychiatric beds has decreased by over 500,000 since the 1950's. This translates to roughly only 12 public beds per 100,000 people nationwide.
- Experts contend that 50 public psychiatric beds per 100,000 people is the minimum number a community can bear, however, one report showed that 42 states of the 50 states had less than half the minimum number needed*.

The Shortage of Public Hospital Beds for Mentally Ill Persons A Report of the Treatment Advocacy Center E. Fuller Torrey, M.D. Kurt Entsminger, J.D.** Jeffrey Geller, M.D.* Jonathan Stanley, J.D.** D. J. Jaffe, B.S., M.B.A..

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Issues of Long Term Boarding

There several issues that result from the long term boarding of behavioral health patients. This includes a number of security and safety concerns such as:

- Elopement attempts (self initiated or with assistance)
- Attempts at self harm (such as suicidal ligature)
- Potential for violence against staff and others
- Regulatory violations as a result of improper restraint and seclusion in response to any of these situations

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Special BH Patient Considerations

When attempting to verbally de-escalate a behavioral health patient or persons that are exhibiting some type of mental instability, keep a few things in mind.

- Do not try to rationalize a course of action with someone who is incapable of rationale decisions.
- While most physical violence is a part of a progressive spectrum of behavior, this is not always the case with behavioral health issues, which can erupt into physical violence with little or no warning.
- Because of this, keep your hands up and out to provide protection for yourself and to minimize possible distractions to the patient.

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Regulatory Issues with Seclusion

Many providers mistakenly think that seclusion involves physical intervention, but it does not. CMS 482.13(e) states, in part that:

“Seclusion is not just confining a patient to an area, but involuntarily confining the patient alone in a room or area where the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room *or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room*, the room is considered locked, whether the door is actually locked or not. In this situation, the patient is being secluded. “

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Regulatory Issues with Seclusion

Joint Commission standard PC.03.05.01 states, in part, that “the hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others”. When de-escalating BH patients, consider:

- Any discussion in which a restraint is threatened to coerce a patient’s behavior can be considered a seclusion even if a physical restraint does not occur.
- This concept can also be expanded to include psychological intimidation (i.e. staff standing at the door with arms crossed to prevent the patient from leaving)
- Seclusion does not require a locked or even closed door. ¹⁴

Interpretive Guidelines for Patient's Rights Standards

- In May 2004, CMS updated the Guidelines to address the use of weapons and handcuffs in restraining patients.
- Language in the Guidelines on use of weapons is the same for both acute medical and behavioral standards.
- “CMS does not consider the use of weapons in the application of restraint as safe, appropriate healthcare interventions.”
- “CMS does not approve the use of weapons by any hospital staff as a means of subduing a patient to place the patient into restraint/seclusion.”

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Interpretive Guidelines for Patient's Rights Standards

- Handcuffs cannot be used by hospital staff to restrain patients as part of a healthcare intervention.
- “Handcuffs, manacles, shackles and other chain-type restraint devices are considered law enforcement restraint devices and would not be considered safe, appropriate healthcare restraint interventions for use by hospital staff to restrain patients.”
- The use of handcuffs or other restrictive devices applied by law enforcement officials (who are not employed or contracted by the hospital) is for custody, detention and public safety reasons, and is not involved in the provision of healthcare.

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Precautions When Treating Forensic Patients

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What Is a “Forensic Patient”

“Forensic patient” is the term commonly used for any patient that is under legal or correctional restrictions, also known as a prisoner patient. They typically require special supervision while being treated at a healthcare facility, usually provided by local, state or federal law enforcement agents.

The mere presence of such patients brings a very specific set of risks to the healthcare organizations and its care providers for a variety of reasons, including unpredictable behaviors, the presence of contraband and, of course, escape attempts.

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Forensic Patient Security Concerns

At times patients that are in Law Enforcement custody will be at your facility (often in the Emergency Dept).

While such patients should receive the same care and attention as other patients, there are certain aspects regarding forensic patient care that are often times overlooked by care givers, such as:

- CMMS Patients' Rights Standards do not apply to law enforcement personnel who bring a prisoner to the hospital for treatment (i.e. routine restraint and seclusion standards) and they determine when handcuffs should be removed.
- All visitation of such patients is at the discretion of the custodial agent regardless of the facility's visitation policy. This to prevent escape attempts as well as the introduction of contraband or other unwelcome behaviors.

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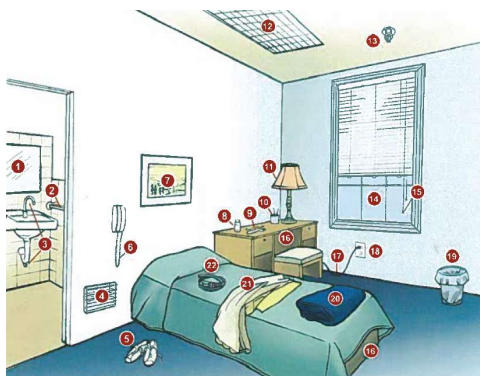
Forensic Patient Escape Study

A comprehensive study regarding prisoner escape attempts from healthcare facilities was conducted by the International Association for Healthcare Security and Safety (IAHSS), and its findings included:

- Escape or elopement attempts were made by the patients either from a clinical treatment area, a restroom, outside of the facility (while being transported into / from a vehicle) and from the Emergency Department in order of frequency.
- In the majority of cases where prisoners escaped, their restraints were partially or completely removed. Restraints were sometimes removed for a procedure (MRI for example) or when a prisoner was asked to change into a hospital gown or requested to go to the restroom.
- Weapons, when used, were typically those taken from their care environment or from personnel guarding them.

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Forensic Patient Environment Checklist



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|--|--------------------------------------|
| 1. Safety Glass/Plastic Mirror | 7. Unsecured Pictures/Glass Frames |
| 2. Towel Bar | 8. Unapproved Medications |
| 3. Exposed Plumbing | 9. Metal Eating Utensils |
| 4. Accessible Ventilation Ducts/Grills | 10. Metal or hard plastic ink pens |
| 5. Shoe/Boot Laces | 11. Unanchored lamps |
| 6. Telephone Cords | 12. Unsecured Lighting Fixture |
| | 13. Non-recessed fire sprinkler |
| | 14. Unsecured window |
| | 15. Mini Blind Cords |
| | 16. Unanchored Furniture |
| | 17. Electrical Cords |
| | 18. Unsecured Electrical Plates |
| | 19. Metal or Hard Plastic Trash Cans |
| | 20. Large/Overstuffed Blankets |
| | 21. Excessive Clothing |
| | 22. Belts |

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Training for Forensic Patient Sitters

If the person will be a long term patient, an educational orientation program for law enforcement agents / sitters and other personnel that will interface with the patient should be considered. Issues for consideration include:

- The law enforcement officer is required to remain with the patient unless requested otherwise by the health care team.
- Sitters should stay alert at all times and be aware of their surroundings to ensure safety for themselves and the patient.
- Unsafe behaviors by sitters (i.e. sleeping, use of headphones, inattention for any reason) should be reported to appropriate clinical and law enforcement personnel.

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Training for Forensic Patient Sitters

- Patients should remain within viewing distance of care givers when in the room and staff should never allow a patient to walk behind them or give them anything.
- Staff should never call the patient by any other name than his or her own name, even if asked to do so.
- Staff should never offer psychiatric or religious advice to the patients. They should give out no personal information about themselves and should report any inappropriate remarks or behavior immediately.
- Law enforcement agents should never be asked to participate in any patient-care activities and should be orientated to the common facility paging alerts and emergency codes and their role during such incidents.

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Security Precautions for Home Health Workers

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The Unique Nature of Home Healthcare

Unlike the previous patient populations that we have discussed, patients receiving healthcare at their home present a number of very distinctive and potentially dangerous issues for providers.

Regardless of security measures that may exist within the organization and at its facilities, none of these exist in the patient's home and thus training for home health staff is critical to their safety.

Recently a case involving the tragic death of a young and inexperienced community health worker demonstrates a dramatic change in how OSHA regards such incidents and the criticality of proper training.

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Secretary of Labor vs. Integra Health

In March of 2019, the Occupational Safety and Health Review Commission ("OSHRC") issued a decision on the Secretary of Labor's power to issue citations under the General Duty Clause relating to the prevention of workplace violence in a case involving Integra Health Management*.

In this case, a young community health worker was stabbed to death by a behavioral health patient at his home during a follow up needs assessment visit. The victim had reported that the patient had made her "uncomfortable" in previous visits and records show that the patient had a long history of violent and criminal behavior at the time of the event.

One of the more important aspects of this unique case and its findings is that the decision may have set a precedent regarding the "foreseeable" nature of violent events and the impact of the OSHA General Duty clause on WPV events.

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*https://www.oshrc.gov/assets/1/6/Integra_Health_Management,_Inc.,_Docket_No._13-1124.htm

OSHA and the General Duty Clause

Although there is no federal occupational safety and health standard for workplace violence prevention, OSHA may issue citations to employers for violating a certain provision of the OSH Act—referred to as the general duty clause—which requires employers to provide a workplace free from recognized hazards likely to cause death or serious harm.

To cite an employer under the general duty clause, OSHA must have evidence that

- (1) a condition or activity in the workplace presents a hazard to an employee,
- (2) the condition or activity is recognized as a hazard by the employer or within the industry,
- (3) the hazard is causing or is likely to cause death or serious physical harm, and
- (4) a feasible means exists to eliminate or materially reduce the hazard.

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Training Considerations for Providers

Home healthcare personnel training should include specific security and safety related issues, to include a robust program on de-escalation techniques and situational awareness, such as:

When visiting a new client:

- Verify the address and research multiple routes to and from the person's home and check their cell phone signal upon arrival.
- Look for dead end streets, construction areas, or anything that might prevent them from easy exit from the area.
- Inform others of their itinerary and when they expect to be done.
- Have a plan if they have not made contact by a certain time.
- Arrange a "password" that will indicate to those they are calling that they need immediate assistance without alerting others.

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Use of a Code Word or Phrase

If you need to summon assistance right away when physical warning signs present themselves consider the use of a code word or phrase that only you and your teammates know the meaning of. If it is used, this means “I need help” and to contact either local police or security right away and have them respond immediately to the site.

- The code word or phrase should be simple and easy to remember
- It should not be something that can be confused for another issue
- All staff should learn this code word as part of their initial orientation to the work environment and it should be reinforced periodically at staff meetings and other educational and information sharing sessions
- The name “**NORA**” (**N**eed **O**fficers **R**ight **A**way) is a good example, or “**EDNA**” (**E**mergency **D**eveloping, **N**eed **A**ssistance)

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Training Considerations for Providers

Prior to exiting their vehicle at the residence, providers should:

- Note any unusual or suspicious activity in the area.
- Look for indications of large animals (such as dogs) around the home they are visiting.
- Consider pre-dialing 911 on their phone prior to entering the home, in case of a dangerous situation they only need to hit one button to make the call, or use a mobile duress system or app.
- Make note of the address of where they are in case a situation arises that they need assistance so police can find it quickly.
- Avoid parking where they could easily be block by another vehicle.
- Look for exits from the home and from the area, and keep these in mind in case they need to leave in a hurry.

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Training Considerations for Providers

Once inside the residence, providers should:

- Be on the lookout for any obvious signs of criminal or illicit activities, such as weapons, drugs or precursor materials.
- Ask the client who is currently at home and if they are expecting any visitors during the appointment.
- Position themselves so that they have a clear view of what is going on around them and so that at least one exit is accessible.
- When ready to leave, they should take their keys out, look both ways and pay attention to any changes from when they arrived.

If illegal activity is observed, providers should do their best not to alert others of their suspicions. They should have a pretext reason ready to allow them to leave at once and call for assistance when safe to do so. They shouldn't touch any items, open any unknown containers or boxes and should not partake of any food or beverages if offered (have an excuse prepared).³¹

Long Term Care Residents

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Unique Challenges of Long Term Care

Long term care includes many different types of facilities such as nursing homes, assisted care sites, rehabilitation hospitals and even continuing care retirement communities. While each differ based upon services, they share some common security issues.

Shared security and safety concerns for any LTCFs can include :

- Crimes of opportunity, particularly the theft of valuables.
- Exploitation of residents by visitors, staff or other residents.
- Elopement attempts, especially of residents suffering from dementia, Alzheimer's or cognitive impairment.
- Workplace violence (both internal or external sources).
- Disasters requiring evacuation of non ambulatory residents .

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Crimes of Opportunity

Many LTC residents may maintain items of significant value especially items that are vulnerable to loss or theft such as jewelry and investigating such losses can prove to be very challenging several reasons (cognitive impairment of the victim, lack of witnesses, etc.).

It is imperative that such facilities have a process in place to properly document items of value that will remain with residents and urge family members whenever possible to secure such items elsewhere.

Documenting such items should include full descriptions, photographs and where the items are usually kept. This should be updated from time to time based upon the resident's situation.

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Crimes of Opportunity

To deter such losses, staff at long term care facilities should be educated on the basics of crime prevention, such as:

- Appropriate visitor management protocols (identifying unknown persons in resident areas particularly after normal visitation).
- Cataloging of resident's valuables and common sense security matters such as keeping exterior doors and windows secured.
- Reporting suspicious incidents in a timely manner to the proper personnel (See Something, Say Something).

The theft of a long term care resident's valuables is not only a financial loss but in many cases it is an emotional blow as well especially regarding the loss of items with high sentimental value.

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Exploitation of Residents

Another common problem that many long term care facilities have to deal with is the exploitation of its residents by visitors, staff or even other residents. Such manipulation and abuse is often made easier due to a resident's willingness to trust others and the issues previously mentioned regarding a decline in mental acuity.

Exploitation can take many forms including:

- "Borrowing" of money without the intention to repay
- Overcharging for real or fictitious services
- Using the residents in illicit activity such as prescription fraud.

While everyone is a potential victim of crime, the elderly are at greater risk since cognitive impairment can diminish the ability to make financial decisions and detect fraud. Scams targeting the elderly include relatives in need, charity appeals, made-up lottery or sweepstakes, identity theft and fake social media relationships.

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Elopement of Residents

There are many type of long term care facilities including those that have residents with some level of cognitive impairment, whether formally diagnosed or not. These residents are at risk for purposeful or unintentional elopement, and the results can be tragic.

- A purposeful elopement might be a resident that decides to return to their home or if they have access to a vehicle (i.e. at a retirement community) to take a road trip without telling anyone.
- Unintentional elopements can include simply wandering away or getting locked out of the facility after hours and being unable to get back in (which can be deadly based upon weather conditions).

Effective security controls such as alarms, cameras and wander alert type systems for at risk residents as well as staff education is³⁷ critical to prevent such tragedies from occurring.

Workplace Violence in Long Term Care

While it has been well documented that the healthcare and social assistance industries have the highest rates of workplace violence in the U.S., many do not consider that long term care facilities suffer from a large number of these types of issues, with many taking place in a skilled nursing type of setting.

Verbal, physical, and sexually aggressive behaviors of residents against long term caregivers as well as against one another is a danger, since a person may be cognitively disabled but physically capable of moving around the facility. Examples can include

- Cursing, yelling and / or screaming at others;
- Hitting, kicking or biting;
- Sexual incidents, such as exposing oneself or sexual contact.

³⁸

Assaults in Long Term Care

Violence can also manifest itself in the form of assaults by external sources, such as a domestic disturbance which overflows into the facility or a family member unsatisfied with the treatment of their loved one. Family members can become emotionally charged when interacting with staff, especially when there is any type of perceived mistreatment or lack of treatment.

Sexual assaults of residents can also originate from multiple sources, including staff or other residents, and any resident can be at risk for these this type of crime from visitors as well.

Another issue to consider is that of those who are patients as a result of engaging in criminal activity, such as the victims of gang violence in a rehabilitation facility. While uncommon, such residents can create major issues for others at the facility due to their behaviors and possible problems with visitors.

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De-escalation for LTC residents

When attempting to verbally de-escalation a long term care resident, you may face some unique challenges based upon the person.

- The person might have an issue with communication due to physical limitations, such as loss of hearing or eyesight and may not recognize who you are.
- While most physical violence is a part of a progressive spectrum of behavior, this is not always the case with cognitive impairment, which can erupt into physical violence with little or no warning.
- Because of this, keep your hands up and out to provide protection for yourself and to minimize possible distractions to the patient.

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In Conclusion

Special patient populations such as those discussed today present a challenging situation for providers, not only due to their vulnerability and potential for unpredictable behavior, but also due to the many legal and regulatory issues that must be taken into consideration when working with these types of clients.

While many resources exist to assist with such situations, one of the most effective approach's is that of multidisciplinary planning and training between clinical personnel, security and support personnel. Local law enforcement should also be involved to get the most up to date information on how to respond when incidents occur involving these types of patients and any pertinent lessons learned after an event has been resolved.

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Discussion



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