DE-ESCALATING VIOLENCE IN HEALTHCARE

STRATEGIES TO REDUCE EMOTIONAL TENSION AND AGGRESSION

S. E. McKnight
Violent incidents are more than four times as likely to occur in healthcare settings than in other professional workplaces, taking a toll on healthcare workers and spurring providers and policymakers to solve the increasing impact of violence.

The most beneficial method of preventing healthcare violence is de-escalation—using therapeutic communication and interventions to defuse emotional tension. In *De-Escalating Violence in Healthcare*, author S. E. McKnight provides tools and techniques to help nurses and other healthcare professionals manage aggressive behavior and foster a safer workplace.

Readers will learn to:

- Understand the variables, risk factors, and triggers of aggression and violence
- Assess mental health status and practice conflict resolution and crisis intervention
- Identify and manage difficult behavioral issues associated with schizophrenia, dementia, bipolar disorder, anxiety, and other conditions
- Foster a caring and healing environment to reduce violence
- Build a healthcare violence prevention program

“This book is a must-read for anyone working in healthcare. The author tackles the ‘elephant in the room’ and provides the reader with compelling, practical strategies to de-escalate violent behaviors in the clinical setting.”

—Crystal G. Bennett, PhD, RN Lecturer, Usha Kundu, MD College of Health School of Nursing University of West Florida

**S. E. McKnight, DNP, MSN, BA, RN-BC**, a mental health educator for more than 22 years, is an adjunct instructor at the University of West Florida. She divides her time among clinical practice, training, consulting, scholarly writing, and research, focusing on de-escalation training to prevent violence and promote holistic wellness and recovery. McKnight developed the first competency-based mental health learning needs assessment for professional nursing practice, which has been published by the American Psychiatric Association as a best practice instrument for research and education.
ABOUT THE AUTHOR

S. E. MCKNIGHT, DNP, MSN, BA, RN-BC, is a career mental health educator who has served in a compassionate mental health nursing practice for more than 22 years. Her specialty is de-escalation training to prevent violence and promote holistic wellness and recovery. No longer a skill practiced only by the mental health disciplines, de-escalation has become a critical skill for all healthcare practices, domains, and disciplines. McKnight has had the privilege of witnessing the dramatic transformation of chaotic healthcare environments into safe, caring, and healing environments with the implementation of de-escalation education programs for all healthcare staff. Presently McKnight teaches mental health nursing at the University of West Florida in Pensacola, Florida, where she educates the next generation of healthcare professionals in safe, holistic nursing care.

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McKnight develops and publishes research in many academic scholarly journals and has contributed to several books. She developed the first competency-based mental health learning needs assessment for professional nursing practice. This needs assessment is published in the American Psychiatric Association database as a best practice instrument for use in both research and education. Her clinical experience has included psychiatric consultation and liaison nursing, addiction recovery counseling, psychiatric emergency department triage, and crisis counseling. McKnight has also worked as an educator for inpatient adult, geriatric, child, and adolescent behavioral health facilities. While working in various clinical positions, she developed and taught specialized evidence-based education programs focused on de-escalation and violence prevention. McKnight delivers workshops and seminars on violence prevention education programs focused on safety.

She is an active member of many professional nursing organizations, including the National League for Nursing, the American Psychiatric Nurses Association, the American Nurses Association, and the American Holistic Nurses Association. McKnight divides her time among clinical practice, training, consulting, scholarly writing, and research.
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INTRODUCTION

Welcome to the instructor’s guide for De-Escalating Violence in Healthcare. We hope this guide will make it easier to educate students on de-escalation techniques for safety in healthcare facilities. The instructor’s guide is a user-friendly resource to accompany the student workbook and text for educational development in the core concepts of de-escalation and safety. One of the most valuable skills a healthcare worker can ever learn and implement, de-escalation involves using therapeutic communication and interventions to defuse agitated patients to prevent them from escalating to dangerous levels of aggression or violence. De-escalation is about preventing violence from occurring.

Healthcare facilities are high stress environments where crisis situations that can trigger agitation in most anyone are everyday occurrences. The Bureau of Labor Statistics reported that 52% of workplace violence incidents occurred in healthcare settings (Occupational Safety and Health Administration, 2015). Research indicates that when a situation involving an aggressive person is effectively de-escalated, violence is reduced. De-escalation is the least restrictive intervention recommended by The Joint Commission (2018) to prevent aggression and violence. It also decreases patient stress and anxiety and allows agitated patients to feel understood. De-escalation as a first response is key to reducing violent incidents in healthcare facilities.

The instructor’s guide contains 20 chapters—one chapter for each corresponding concept presented in the textbook. The instructor’s guide and student workbook chapters are divided into four sections: role play group discussion activity exercise, case study, discussion review questions, and quiz. Answers to the review questions are provided in the instructor’s guide for the student workbook. Each chapter’s case studies, role play, quiz, and discussion review questions greatly benefit students in developing competency in de-escalation skills. The case studies give realistic examples of situations a healthcare worker may encounter. The role play exercise simulates patient behaviors, feelings, and thinking patterns; it replicates the nurse-patient therapeutic interaction to make the scenario come alive in students’ minds, helping them visualize the encounter and improving their comprehension of de-escalation and effective implementation. The discussion review questions incorporate active learning in the classroom setting or in small group work, giving students an opportunity to develop critical thinking skills. The quiz questions assist the students in refining thinking and developing test-taking skills.

Training in de-escalation techniques and experience in practicing the techniques are essential in developing competency in therapeutic application. A competency-based education curriculum on de-escalation emphasizes development of knowledge and skills. One of the greatest challenges for healthcare instructors is to develop and verify de-escalation competency in students for best-practice, quality care. De-escalation competency is not developed simply by teaching the student a proper technique. To determine competency, the student must give a correct return demonstration of the de-escalation technique that was taught. That is where the role play group discussion activity exercises in the student workbook come in. The role play of the case study scenarios is a simulation activity that provides an opportunity for students to give a return demonstration of therapeutic de-escalation techniques learned in the education as well as practice time to develop mastery and competency of the skill. Instructors can then evaluate the student’s role play activity return demonstration of de-escalation techniques implemented for determination of competency attainment.

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The student workbook contains role play group discussion activity exercises that are based on realistic case study situations a healthcare worker might encounter. The role play exercise gives students an opportunity to experience applying the de-escalation techniques learned in each chapter to develop competency. There is a role play exercise for every chapter and de-escalation concept in the book. In each exercise, a case study is presented, and then two or more student volunteers are selected for the role play on the case study scenario. One student participant assumes the role of the agitated patient and the other student the therapeutic healthcare worker using appropriate techniques to de-escalate the patient. This gives students an opportunity to practice and develop their de-escalation skills. The remaining students view and critique the role play student interactions and their effectiveness in utilizing de-escalation techniques. After the role play exercise, the instructor facilitates a group discussion evaluating the role play initiated. In the discussion, the instructor encourages students to discuss an application of de-escalation techniques beneficial in that type of scenario interaction. Each case study role play exercise is an opportunity to learn and develop therapeutic de-escalation competency. The exercise is the return demonstration evaluation necessary for assessing development of de-escalation competency for nurses and other healthcare professionals to improve safety in healthcare facilities.

The student workbook contains de-escalation discussion review questions for each chapter, presenting pertinent concepts of de-escalation and violence prevention to stimulate skill development and critical thinking. The instructor facilitates student group discussions of the chapter’s topics, presented with students answering and analyzing the different discussion topics.

Each student workbook chapter also has a de-escalation quiz to empower learning and enhance retention of learned education. Only the instructor’s guide will contain the answers to the quiz questions, which are focused on the most important elements of de-escalation education and its focus on safety and violence prevention. Instructors can use the questions as a pop quiz to determine students’ accuracy in comprehension of de-escalation education. The quiz can help to clarify any faulty thought processes, correct misinformation, and help students learn from their mistakes.

In the workbook chapters, students will explore and learn the concepts of aggression (including risk factors), de-escalation, and therapeutic communication. They will also learn how to perform mental status assessments, manage and even prevent aggressive behavior, practice conflict resolution, and—when faced with individuals with depressive disorders, suicidal ideation, or self-injurious behavior—engage in crisis intervention. Debriefing, reporting, and documenting a de-escalation encounter are detailed after the incident. Specific therapeutic interventions for difficult behavioral issues associated with schizophrenia, dementia, bipolar disorder, delirium, anxiety, and panic disorders are also covered. In addition, stress management techniques to help patients cope; tips for creating a calming, caring, and healing environment to stop violence before it starts; and a framework for building a healthcare violence prevention plan are included. Nursing instructors and healthcare professionals of all educational levels will find this book immensely valuable in promoting and advancing the commitment to education for healthcare violence prevention. The goal of this guide is to help instructors educate healthcare students to develop skill as well as competency in de-escalation to prevent healthcare violence and foster a safe healthcare workplace that benefits all and promotes peace and safety for everyone.
REFERENCES


De-escalation is the vital process of helping a person regain self-control by lowering emotional tension with the use of therapeutic communication and interventions to diffuse agitation. This process prevents the patient from escalating to dangerous levels of aggression or violence.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 1.1. Role-play with one person as the agitated patient and the other as the caregiver. Have each participant discuss application of a de-escalation technique beneficial in resolving the situation successfully. Afterward, facilitate a group discussion evaluating the simulated role play initiated.

CASE STUDY 1.1: THE DE-ESCALATION PROCESS

Glen is a 42-year-old male arriving to the medical unit of a community hospital today for a routine surgical removal of a shoulder cyst. He is expected to receive the procedure today, then stay overnight and return home first thing the next morning. During admission, Glen says he is a single, self-employed manager of his own remodeling business. No family members accompany Glen when he arrives to his inpatient room. He states he is an only child, and his mother has recently passed away. He lost his father years ago in an auto crash. Glen says he lives alone, and he arrives to the unit irritable, angry, and distressed. He talks about his fear of the procedure, stating “I am afraid it will hurt” and “I don’t know what is going to happen.” The nurse arranges the supplies to start the required IV for the surgical procedure and notices Glen has balled up both fists and is scowling angrily at her. He looks up at the nurse and shouts loudly, “Are you about to hurt me?”

HOW DO YOU RESPOND IN THIS ENCOUNTER?

Answer: Assess the situation by observing that Glen is alone and has body language clues of escalation—including scowling, shouting, anger, irritability, and clenched fists—and is in a fearful state. Implement safety measures immediately by activating the “buddy system”—summon a staff member to stand in the doorway while you calmly assure Glen that he is safe. Step back a few feet to give him an adequate personal space for comfort and to reduce anxiety. Apply de-escalation techniques by showing respect; speak in a calm, caring tone of voice and call him by his proper name or “sir.” Explain the procedure step by step in a caring, considerate manner. Ask open-ended questions (those that cannot be answered with a yes or no) to encourage verbalization and determine understanding of the procedure. Encourage his cooperation and assistance in the procedure with open, honest, caring communication. After he has calmed and regained self-control, debrief to determine how the situation can be prevented in the future. Report and document the de-escalation encounter in the electronic health record and nursing report and notify the provider and supervisor on duty.

DE-ESCALATION PROCESS DISCUSSION REVIEW QUESTIONS

1. DESCRIBE WAYS TO ASSESS THE SITUATION AS PART OF THE DE-ESCALATION PROCESS.

Answer: Assess risk factors for aggression (patient, environment, and caregiver) and body language clues to escalation, and implement de-escalation techniques early.
2. WHAT ARE SOME SAFETY MEASURES FOR DE-ESCALATION ENCOUNTERS?

Answer: Activate a buddy system for safety; never attempt to de-escalate a person alone. Do not become isolated with an agitated person. Always have one or more coworkers stand by for safety. Position yourself near a doorway at a safe distance. Speak to the patient in a calm, caring, respectful manner.

3. DISCUSS SOME EFFECTIVE DE-ESCALATION TECHNIQUES.

Answer: Encourage verbalization, such as talking with healthcare staff, family, or friends. Provide reading material, such as a book, Bible, or magazine. Invite the patient to take a nap or have quiet time. If confused, re-orient to reality. Offer a warm blanket or extra blanket. Engage in reminiscence therapy. Encourage journal writing. Remove from an over-stimulating (noisy or crowded) environment. Take the patient for a walk or do hand exercises, such as folding towels or drawing pictures. Offer nourishment supplements such as an extra snack. Provide puzzles or games to work on. Teach the patient how to do relaxation exercises. Maintain a calm, caring, professional demeanor and role-model appropriate behavior. Use therapeutic communication and restatement, ask open-ended questions, and listen to the patient. Show courtesy as well as respect. Avoid power struggles.

4. LIST SOME IMPORTANT ELEMENTS OF DEBRIEFING.

Answer: Debrief both the patient and all staff involved in the acting-out event. Ask each participant what happened, and request suggestions on how the situation can be prevented from occurring in the future.

5. DESCRIBE HOW TO REPORT AND DOCUMENT A DE-ESCALATION ENCOUNTER.

Answer: Report the incident to the provider on duty, such as the physician, psychiatrist, or nurse practitioner, as well as the nurse manager or supervisor. Describe the incident in the nursing unit report, and document the de-escalation encounter in the electronic health record. Some facilities may also require that a separate incident report be completed.
DE-ESCALATION FOR HOLISTIC WELLNESS QUIZ

1. What is a major cause of escalation on inpatient units?
   A. Excessive noise
   B. Staff
   C. Food
   D. All of the above

   Answer: A. Excessive Noise

2. TRUE or FALSE: De-escalation is a valuable tool in the prevention of workplace violence.

   Answer: TRUE

3. An effective verbal de-escalation technique is:
   A. Close-ended questions (can be answered with yes or no)
   B. Open-ended questions to encourage verbalization
   C. Both A and B
   D. None of the above

   Answer: B. Open-ended questions to encourage verbalization

4. The nurse’s core role in family care is to:
   A. Provide education
   B. Give emotional support
   C. Both A and B
   D. None of the above

   Answer: C. Both A and B

5. TRUE or FALSE: Personal stress can make a person angry, agitated, and aggressive toward others.

   Answer: TRUE
Aggression is defined as harsh physical or verbal actions with the intent to harm another physically or mentally (Townsend, 2015). Unchecked aggression can escalate to violence.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 2.1. In the role play exercise, one participant assumes the role of the patient and the other the therapeutic healthcare worker. Have each participant discuss application of a variable or risk factor related to violence. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 2.1: AGGRESSION RISK FACTORS

Renaldo is a 46-year-old male admitted to an inpatient surgical unit for GERD (gastroesophageal reflux disease) after having severe intestinal distress for over three weeks at home. He is admitted to a unit with ongoing construction to build an adjoining wing. The construction noise is continuous on the unit until late evening. Renaldo has a history of poor impulse control and violence. He states on admission that he is on probation for domestic violence charges. Renaldo says, “I have a short fuse and can’t handle stress” and “My wife got in the way, so I slapped her down.” He states he has a court date for domestic violence next month. He complains of “ulcers” from the anxiety of waiting for his court appointment. Renaldo says, “I don’t know what will happen with my kids.”

WHAT ARE SOME RISK FACTORS FOR ESCALATION THAT RENALDO MAY ENCOUNTER WHILE AN INPATIENT?

Answer: Stressful environment, physical pain, excessive external stimuli, excessive noxious noise, frequent invasion of personal space, overcrowding, lack of privacy, lack of autonomy, boredom, staff who are difficult or busy, rigid routines, lack of flexibility, and unpredictability of other patients and environment.

RISK FACTORS FOR AGGRESSION DISCUSSION REVIEW QUESTIONS

1. LIST AND DISCUSS PATIENT RISK FACTORS FOR AGGRESSION AND VIOLENCE.

Answer: Patient risk factors include observable behaviors such as agitation, restlessness, anger, and disorganization. Individuals who carry the greatest risk for harmful intent are those with a detailed or planned threat of violence and available means for inflicting injury, such as ownership of a weapon. Other patient risk factors include the presence of mental instability, delusions, and command hallucinations with violent content. Poor impulse control and violation of personal space are also substantial indicators. Additional risk factors include irritability; attention-seeking behavior; and progressive psychomotor agitation, such as pacing. Paranoid symptoms, such as voicing thoughts of delusions or persecutions, may indicate increased potential to become physically aggressive. Substance intoxication or withdrawal from alcohol or illegal drugs may increase potential for agitation. Allergic reactions to medication or medication toxicity can cause altered mental states. Paradoxical rage can
increase the risk for physical aggressiveness toward caregivers and others. The best single predictor of aggression is a history of violence.

2. LIST AND DISCUSS POSSIBLE ENVIRONMENTAL RISK FACTORS FOR AGGRESSION AND VIOLENCE.

Answer: Environmental factors—including excessive external stimuli, noise, overcrowding, and the unpredictability of the ever-changing inpatient healthcare populations and environments—may result in agitation. Other risk factors include a lack of personal space and privacy. There is increased risk related to lack of patient autonomy and inability to control decisions in healthcare. Inpatient facility levels of stimulation—such as overly loud, noisy environments or under-stimulating environments that lack recreational and diversional activities—contribute to aggression potential. Lack of structure and unpredictable schedules in healthcare environments also increase the risk of aggressive behavior toward others.

3. LIST AND DISCUSS CAREGIVER RISK FACTORS FOR VIOLENCE AND AGGRESSION.

Answer: Caregiver factors impacting inpatient aggression include educational level of staff and lack of staff education in de-escalation techniques. Work experience of staff is also a vital factor in aggression prevention. Rigidity of routines may trigger violence in some patients. Caregiver attitude and skill impact the risk of inpatient aggression and violence. Healthcare professionals who are not available to patients, both physically and emotionally, are more at risk for encountering aggression than those who offer availability to listen.

4. LIST AND DISCUSS PATIENT AND CAREGIVER INTERACTION THAT MAY INCREASE RISK OF AGGRESSION/VIOLENCE.

Answer: Power struggles are the interaction factors most associated with aggression and violence. Nursing staff who have “high expressed emotion,” such as a loud, high-pitched tone of voice; high anxiety; or an inclination to overreact to situations have a greater risk of encountering physical aggression.

5. DISCUSS THE GOALS AND INTERVENTIONS FOR RECOVERY-ORIENTED CARE.

Answer: The goal of recovery-oriented care is to refrain from aggressive behaviors toward self or others. For effective prevention of aggression and violence, implement de-escalation education as well as comprehensive therapeutic interventions focused on the patient, caregiver (nurse), and environment.
RISK FACTORS FOR AGGRESSION QUIZ

1. Robust evidence suggests that violence and aggression are associated with which risk factors?
   A. Patient risk factors
   B. Environmental risk factors
   C. Caregiver risk factors
   D. All of the above

   Answer: D. All of the above

2. TRUE or FALSE: Aggression is defined as harsh physical or verbal actions with intent to hurt or harm another person mentally or physically.

   Answer: TRUE

3. Patient risk factors for aggression and violence include:
   A. Agitation, restlessness, anger, and disorganization
   B. Detailed or planned threat of violence
   C. Impulsiveness, delusions, and command hallucinations with violent content
   D. All of the above

   Answer: D. All of the above

4. One of the major caregiver risk factors for inpatient aggression is:
   A. Nurses with higher education
   B. Lack of staff education in de-escalation techniques
   C. Both A and B
   D. None of the above

   Answer: B. Lack of staff education in de-escalation techniques

5. TRUE or FALSE: Noise and lack of privacy are two major causes of agitation and aggression in inpatient medical facilities.

   Answer: TRUE

REFERENCE

Assessment is defined as the process of gathering as well as analyzing patient subjective and objective information to determine status (Thompson, & Wilson, 1996).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing Case Study 3.1. In the role-play exercise, one participant assumes the role of the agitated person and the other the therapeutic healthcare worker. Have each participant discuss applying an assessment beneficial in preventing violence and resolving the situation successfully. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 3.1: ASSESSING AN ESCALATING SITUATION

Andrea is a 32-year-old female admitted to a medical facility for removal of an ovarian cyst. She is alert and oriented with a history of bipolar disorder. Andrea has in the past been described as moody. Depending upon what was happening in her life, Andrea could be very sad and depressed or very joyful and happy. During her depressed times, she felt fatigued and spent most of her time in bed, too exhausted to even bathe or dress. During her happy times, she went to parties and was very outgoing, with a remarkable amount of energy and endurance. These times were marked by insomnia and an inability to rest or sit still. Andrea graduated from college with a master of business administration degree. Since that time, she has been employed as the vice president of a large multinational company. Today, you are assigned as the primary caregiver to Andrea during her hospital stay. When you walk into the room, you notice that she has a tense posture and is sitting by a window. She is clenching and unclenching her fists. As Andrea speaks, her voice is loud, and she yells, “My breakfast tray is late getting here.”

HOW DO YOU RESPOND TO THIS ENCOUNTER?

Answer: Use therapeutic communication. Ask Andrea open-ended questions (those that cannot be answered with a yes or no) to encourage expanded verbalization. Use empathetic, respectful, and gentle methods of communication. Address her properly by name, Ms. or Mrs., or ma’am. Utilize engaged listening skills and appropriate proxemics (distance), and communicate with clear, easily understood information. Offer to help. Try to find, and resolve, the troubling issue that is causing her distress. Assess her for pain and encourage relaxation exercises. Offer her a book to read or turn on the television or radio.

ASSESSING AN ESCALATING SITUATION DISCUSSION REVIEW QUESTIONS

1. DESCRIBE SOME BODY LANGUAGE CLUES OF ESCALATION.

Answer: Tense posture, fidgeting, hand-wringing, pacing, foot tapping, irritability, abrupt movements, cursing, shouting, angry facial expressions, harsh voice, backing into a corner or closed area, anxiety, breathing changes, demanding behavior, mumbling, destroying property, red face, distended neck veins, furrowed brow, teeth clenching, hands clenching, intimidation, refusal to follow directions, verbal threats, pounding hand into palm, and swinging arms.
2. DESCRIBE THE ASSESSMENT PROCESS OF CAPLAN’S ASSAULT CYCLE.

**Answer:**

**Activation.** Patient may exhibit body language that indicates agitation, such as pacing. Or, patient may shout at family members.

**Escalation.** Patient displays disruptive behaviors such as shouting, cursing, or making hostile or unreasonable demands.

**Crisis.** Patient acts out in aggressive or violent ways—for example, shouting, striking out, or biting others.

**Recovery.** De-escalation interventions are working, and patient is regaining self-control. Patient begins to get a grip on emotions.

**Post-crisis depression.** After regaining control, the patient may feel embarrassed or remorseful about the incident and may become depressed or despondent. Patients in this phase may become teary and often will apologize profusely to staff for their previous actions.

**Stabilization.** Patient has completely regained self-control and reestablished normal behavior—and is restored to his or her normal routine.

3. DISCUSS TRIGGERS OF VIOLENT OR AGGRESSIVE BEHAVIOR.

**Answer:** Attempts to protect vital interests, alcohol or substance abuse, aggressive or hostile staff, change in role identity, expectations of staff, lack of alternative methods of expression, lack of individual space, impaired communication, loss of meaningful activity, increased frustration or confusion, diminished self-esteem, loss of sense of purpose, physical disabilities, and physical pain.

4. EXPLAIN THE CYCLE OF ESCALATION AND SOME BEHAVIORS ASSOCIATED WITH EACH STAGE.

**Answer:**

**Anxious.** Tense posture, fidgeting, pacing, hand-wringing, foot tapping, and irritability

**Agitated.** Clenched teeth, clenched fists, cursing, and shouting

**Aggressive.** Intimidating behavior, insulting, threatening, slamming doors, violating rights of others, intruding into the personal space or privacy of others, and destroying property

**Violent.** Striking, punching, slapping, biting, hair-pulling and throwing objects to injure
5. DISCUSS THE IMPORTANCE OF EARLY INTERVENTION WITH DE-ESCALATION TECHNIQUES.

Answer: The earlier a de-escalation intervention is initiated, the better the chance for success. De-escalation breaks the cycle of escalation, preventing the patient from losing control.

ASSESSING AN ESCALATING SITUATION QUIZ

1. The escalation cycle is:
   A. Calm, anxious, agitated, aggressive, violent
   B. Calm, agitated, violent
   C. Agitated, aggressive, violent
   D. Agitated, anxious, violent

   Answer: A. Calm, anxious, agitated, aggressive, violent

2. TRUE or FALSE: Physical pain can be a significant precipitant to aggressive or violent behavior:

   Answer: TRUE

3. Strategies for successful de-escalation include:
   A. Early de-escalation
   B. Ignoring the behavior
   C. Shouting
   D. Being argumentative

   Answer: A. Early de-escalation

4. The aggression continuum begins with:
   A. Calm
   B. Anxiety
   C. Crisis
   D. Stress trigger

   Answer: D. Stress trigger

5. Safety goals of de-escalation include:
   A. Redirect to calm.
   B. Defuse difficult situation before self-control is lost.
   C. Open lines of communication.
   D. Identify and reduce as many stressors as rapidly as possible.
   E. All of the above

   Answer: E. All of the above
REFERENCE

Verbal de-escalation involves encouraging the agitated person to verbalize thoughts, feelings, and problems instead of acting out pent-up emotions aggressively (Hallett & Dickens, 2015; Richmond et al., 2012).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 4.1. In the role play exercise, one person assumes the role of the agitated patient and the other a therapeutic healthcare worker. Have each participant discuss application of a de-escalation technique beneficial in resolving the situation successfully. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 4.1: DE-ESCALATION TECHNIQUES

Marie is a 92-year-old female admitted as an inpatient to a medical hospital for osteomyelitis of her left foot. She has a long-term history of Alzheimer’s disease, beginning at age 84. Marie is disheveled and disoriented to person, place, time, and situation. She is on bedrest until the orthopedic physician sees her. The nurse answers a call light to Marie’s room. Upon entering, the nurse sees Marie struggling to get out of bed. Marie sees the nurse and angrily states, “I have to go run down the street and get my mail” and “Don’t you get in my way ‘cause the president is coming to see me.”

HOW DO YOU RESPOND IN THIS ENCOUNTER?

Answer: Use de-escalation interventions to re-orient Marie to reality. Encourage verbalization, watching TV, or nap/quiet time. Offer her a warm blanket or extra blanket, reminiscence therapy, hand exercises such as folding towels or drawing pictures, snacks, puzzles or games, relaxation exercises, or music.

DE-ESCALATION TECHNIQUES DISCUSSION REVIEW QUESTIONS

1. DESCRIBE DE-ESCALATION TECHNIQUES FOR CALMING AND VIOLENCE PREVENTION.

Answer: Encourage verbalization; talking with healthcare staff, family, or friends; reading a book, the Bible, or a magazine; watching TV; taking a nap; or having quiet time. Re-orient to reality. Offer warm blanket or extra blanket, reminiscence therapy, or journal writing. Remove from over-stimulating (noisy or crowded) environment. Suggest going for a walk, hand exercises such as folding towels or drawing pictures, nourishment supplements, puzzles or games, relaxation exercises, or music.

2. WHAT ARE SOME DE-ESCALATION COMFORT MEASURES TO CALM AGITATED PATIENTS?

Answer: Offer warm blanket or snack. Provide quiet environment. Suggest going for a walk.

3. LIST SOME DISTRACTION TECHNIQUES FOR CALMING:

Answer: Offer puzzles or games; provide reading material such as a book, the Bible, or a magazine; encourage watching television; and offer to turn on pleasant music to listen to and enjoy.

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4. WHAT ARE SOME IMPORTANT TECHNIQUES FOR DE-ESCALATION?

Answer: Maintain a calm, caring, professional demeanor, and be a role model for appropriate behavior. Use therapeutic communication, open-ended questions, and restatement. Show courtesy and respect. Avoid power struggles. Listen to the patient.

DE-ESCALATION TECHNIQUES QUIZ

1. Which of these is an open-ended question to encourage verbalization?
   A. Is this a bad time?
   B. Are you worried?
   C. What are you feeling right now?
   D. All of the above

   Answer: C. What are you feeling right now?

2. TRUE or FALSE: De-escalation is the least restrictive technique to prevent violence and use of restraints.

   Answer: TRUE

3. The best types of music to play for calming de-escalation are:
   A. Music with no words
   B. Music with a slow tempo
   C. Loud music with a lot of words
   D. Both A and B

   Answer: D. Both A and B

4. Principles of safe de-escalation include:
   A. Stay calm.
   B. Show respect.
   C. Offer choices.
   D. All of the above

   Answer: All of the above

5. TRUE or FALSE: Verbal de-escalation involves encouraging the agitated person to verbalize thoughts, feelings, and problems.

   Answer: TRUE
REFERENCES


Therapeutic communication is the set of communication techniques used by caregivers to focus on patients’ needs and to promote the continuous process of healing and change (Townsend, 2015).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 5.1. In the role play exercise, one participant assumes the role of the depressed person and the other the therapeutic healthcare worker. Have each participant discuss application of the therapeutic communication technique beneficial in encouraging verbalization to improve mood and calm the patient. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 5.1: THERAPEUTIC COMMUNICATION

Robert is a 27-year-old male inpatient being treated for pancreatitis. He has a history of depression. While a college student, Robert achieved high grades but dropped out of college for an industrial career as a welder. He never married and lives alone. Robert has little contact with his family; he states, “My family does not understand me, so I don’t visit them but maybe once a year.” Robert’s facial expression is sad and despondent. He is noted to be isolative and withdrawn. Robert is frequently seen sitting alone in his room and never has any visitors. He is visibly depressed, anxious, and quiet.

WHAT THERAPEUTIC COMMUNICATION TECHNIQUES CAN BE UTILIZED IN INTERACTING WITH ROBERT TO ENCOURAGE VERBALIZATION OF ISSUES AND TO IMPROVE MOOD?

Answer: Open-ended questions, repetition or paraphrasing, clarification, perception checking, offering self, presenting reality, focusing, summarizing, and giving feedback.

THERAPEUTIC COMMUNICATION DISCUSSION REVIEW QUESTIONS

1. ANALYZE THE MANY METHODS OF EFFECTIVELY COMMUNICATING A MESSAGE.

Answer: Discuss the many ways a message may be communicated, such as by tone of voice when speaking or by nonverbal communication such as gestures, proxemics, posture, appearance, and facial expressions.
2. EXAMINE THERAPEUTIC COMMUNICATION TECHNIQUES FOR DE-ESCALATION.

Answer: Focus on the patient, maintain a professional attitude, emphasize rationality, use nonthreatening language, don’t judge, don’t change the subject, and give information.

3. DISCUSS IMPORTANCE OF THE FUNDAMENTAL ELEMENTS OF THERAPEUTIC COMMUNICATION.

Answer: The fundamental elements of therapeutic communication are trust, empathy, respect, congruence, listening, and self-awareness.

4. DISCUSS WAYS TO ESTABLISH TRUST AND THERAPEUTIC RAPPORT FOR DE-ESCALATION.

Answer: Identify yourself to the patient upon first contact. Knock on the door of the patient’s room and introduce yourself upon entering. Always give your name, position, and reason for being in the patient’s room. Listen and answer politely. Utilize a staff member who has rapport with the patient. Empower the patient by offering at least two de-escalation interventions and allowing the patient to choose the intervention. Use restatement when the patient speaks. Show respect by being polite and courteous during every interaction. Encourage the patient in calming and regaining self-control. Show empathy and understanding. Acknowledge the significance of the situation to the patient, and ask how you can help with the problem.

5. DISCUSS TECHNIQUES FOR THERAPEUTIC COMMUNICATION WITH PATIENTS WHO ARE HARD OF HEARING OR DEAF.

Answer: Move to a distance of 3 to 6 feet when communicating. If the patient has one ear with better hearing, speak into the good ear for best auditory capacity. Choose an environment that is free of competing noise; turn off television and radio to rid the area of competing sound. Place your face directly in front of a deaf person so your face and lips can be seen clearly for lip reading. During communication with the hard of hearing, speak at a natural rate of speech (Jeffery & Austin, 2005; Kneisl & Trigoboff, 2009).
THERAPEUTIC COMMUNICATION QUIZ

1. The process of therapeutic communication involves which of these concepts?
   A. Message
   B. Sender
   C. Receiver
   D. All of the above
   
   Answer: D. All of the above

2. TRUE or FALSE: Most of the communication that occurs between individuals is nonverbal.
   
   Answer: TRUE

3. The two types of therapeutic communication are:
   A. Open and closed
   B. Difficult and complex
   C. Verbal and nonverbal
   D. All of the above
   
   Answer: C. Verbal and nonverbal

4. Successful communication includes these formal criteria:
   A. Efficiency and appropriateness
   B. Flexibility and feedback
   C. All of the above
   D. None of the above
   
   Answer: C. All of the above

5. TRUE or FALSE: Self-awareness guidelines to improve nonverbal communication techniques include being aware of your own personal appearance, presence, and mannerisms. The simple act of relaxing makes it easier for others to be relaxed in your presence and more open during communications.
   
   Answer: TRUE

REFERENCES


Holistic stress management involves integrating, balancing, and harmonizing all aspects of the body, emotions, intellect, and spirit to move from a place of fear to a place of love and compassion for the self and others (Yu et al., 2019).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 6.1. In the role play exercise, one participant assumes the role of the stressed-out patient and the other the therapeutic healthcare worker assisting with de-escalation. Have each participant discuss stress management techniques beneficial in de-escalation. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 6.1: STRESS MANAGEMENT

Sarah is a 28-year-old female admitted to the medical unit of a local hospital for hypertension. She is alert and oriented, with a thin, frail build. Sarah is employed as a stockbroker with a local firm. She states she is presently going through a divorce, and her husband is seeking custody of both of her children. In addition to the stress of domestic crisis for Sarah, her company is merging with another, and her position with the new firm is not guaranteed. She worries that she may lose her employment and financial support for her children. Sarah arrives to her hospital room anxious, depressed, and reluctant to even speak. As you walk into Sarah’s room, she shouts loudly: “Where have you been? I arrived a whole five minutes ago!”

HOW DO YOU HANDLE THIS SITUATION?

Answer: Ask open-ended questions to encourage Sarah to talk about her problems. Encourage diaphragmatic breathing to reduce emotional tension and stress. Teach relaxation techniques such as meditation, mental imagery, progressive muscular relaxation, and yoga. Turn the radio on to provide calming music. Encourage her to engage in physical exercise.

STRESS MANAGEMENT DISCUSSION REVIEW QUESTIONS

1. DISCUSS COMMON CAUSES OF STRESS IN THE MODERN WORLD.

Answer: Financial problems, global warming, dramatic weather conditions, illness, and lack of health insurance. Other stressors include nonstop communication and ever-changing modern technology and its implications, such as identity theft and loss of privacy.

2. EXPLAIN THE FUNDAMENTAL ELEMENTS OF ALL HUMAN BEINGS.

Answer: Physical bodies, emotions, intellect, and spirit.
3. DISCUSS THE EMOTIONAL EFFECTS OF STRESS.
Answer: Stress is a major contributing factor in depression and suicide and the leading cause of anger, aggression, and violence.

4. DISCUSS HOW HOLISTIC STRESS MANAGEMENT CAN REDUCE TENSION AND ANGER.
Answer: Holistic stress management involves integrating, balancing, and harmonizing all aspects of the body, emotions, intellect, and spirit for emotional healing.

5. DESCRIBE RELAXATION EXERCISES THAT REDUCE STRESS.
Answer: Diaphragmatic breathing, meditation, mental imagery, progressive muscular relaxation, aromatherapy, comfort measures, yoga, music, relaxation recordings, autogenics, and physical exercise.

STRESS MANAGEMENT QUIZ

1. Which of the following are not types of mental imagery?
   A. Scenes that are tranquil and comforting
   B. Scenes in which an individual is seen engaging in health-conscious behavior
   C. Scenes of chaos and crisis
   D. Visualizing their body being healed
   Answer: C. Scenes of chaos and crisis

2. TRUE or FALSE: Diaphragmatic breathing is an effective stress management technique that involves breathing from the lower stomach or diaphragm rather than from the thoracic area.
   Answer: TRUE

3. Progressive muscular relaxation involves _______ and _______ muscle groups while performing breathing exercises.
   A. Tensing and relaxing
   B. Lengthening and shortening
   C. Tapping and holding
   D. All of the above
   Answer: A. Tensing and relaxing
4. What type of environment is best for relaxation exercises?
   A. A noisy room
   B. A quiet room with minimal distractions and a comfortable room temperature
   C. An active hallway with crowds walking by
   D. Outside in freezing temperatures
   
   Answer: B. A quiet room with minimal distractions and a comfortable room temperature

5. TRUE or FALSE: Meditation involves concentrating the mind to empty and cleanse it of stressful thoughts and ego-based worries.
   
   Answer: TRUE

REFERENCE

Conflict resolution is a communication process used to settle conflict. It involves the use of negotiation to reach a solution that is agreeable to all parties.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 7.1. In the role play exercise, one participant assumes the role of the patient and the other the therapeutic healthcare worker. Have each participant discuss application of conflict resolution beneficial in de-escalation. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 7.1: CONFLICT RESOLUTION

Walter is a 37-year-old male visiting an outpatient clinic today for a 10 a.m. appointment. He is seeing his physician for unrelenting migraine headaches lasting for over an hour. The headaches are every day now, and he is being evaluated for a possible brain tumor. When checking in with the receptionist, Walter is told he has arrived a week early, and his actual appointment date is next week. When told he cannot see his physician until next week, Walter starts shouting: “They told me over the phone my appointment was for the 14th, not the 21st. My appointment is today, and I want to see my physician right now!”

HOW DO YOU HANDLE THIS SITUATION?

Answer: Calmly address the underlying problem with Walter. Use an objective, caring, compassionate approach. Discuss the situation and negotiate a solution that benefits both parties. Focus on the most important issue at hand. Communicate with Walter. Listen to him when he is talking and make him aware you are listening. Take a close look at his complaint and see if a solution may be readily available. Check back with him to evaluate the situation and determine if the solution was effective in resolving the problem.

CONFLICT RESOLUTION DISCUSSION REVIEW QUESTIONS

1. DESCRIBE DIFFERENT CONFLICT RESOLUTION STYLES.
   Answer: Avoiding, competing, collaborating, compromising, and accommodating.

2. DISCUSS THE BENEFITS OF THE CONFLICT RESOLUTION PROCESS.
   Answer: Resolves conflict, fosters a safe workplace, prevents violence, and improves morale of both patients and staff.

3. EXPLAIN THE TWO TYPES OF CONFLICT AND HOW THEY DIFFER.
   Answer: Overt conflict is conflict that is out in the open. The conflicting parties tend to perceive their differences as irreconcilable and all possible outcomes as incompatible. Covert conflict is unacknowledged and manifests in powerful undercurrents of volatile emotions.
4. DISCUSS THE TWO BEST STYLES TO SUCCESSFULLY RESOLVE A CONFLICT.
Answer: Collaborating and compromising.

5. DISCUSS THE DIFFERENT TYPES OF CONFLICT THAT CAN OCCUR IN HEALTHCARE ENVIRONMENTS.
Answer: Patient-nurse, patient-patient, patient-family, nurse-nurse, and nurse-interdisciplinary staff.

CONFLICT RESOLUTION QUIZ

1. The two types of conflict are:
   A. Open and closed
   B. Active and passive
   C. Overt and covert
   D. None of the above
   Answer: C. Overt and covert

2. TRUE or FALSE: In conflict resolution, it is important to allow both parties to voice their side of the issue in conflict.
   Answer: TRUE

3. The “avoiding” conflict resolution style (ignoring the conflict) is considered what type of strategy?
   A. Lose-lose
   B. Win-win
   C. Win-lose
   Answer: A. Lose-lose

4. The best conflict resolution style, which is high in both assertiveness and cooperation and utilizes a problem-solving technique to ensure the interests of all parties are met, is:
   A. Competing
   B. Compromising
   C. Collaborating
   D. Avoiding
   E. Accommodating
   Answer: C. Collaborating

5. TRUE or FALSE: A good technique for open communication is to encourage “I” statements.
   Answer: TRUE
A crisis is a debilitating imbalance in one’s internal equilibrium caused by a sudden stressor or threat to the self (Boyd, 2008).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 8.1. In the role play exercise, one participant assumes the role of the patient and the other the therapeutic healthcare worker. Have each participant discuss application of a crisis intervention beneficial in de-escalation. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 8.1: CRISIS INTERVENTION

Alice is a 23-year-old alert and oriented female seen today in the emergency department (ED) for evaluation of a stab wound to her left arm. She was brought into the ED by ambulance with three other individuals after a party held on campus at a local community college. Alice has noticeable amounts of blood smeared over her face, arms, and clothing. She sits visibly shaking on a gurney in the treatment room as she holds her head in her hands. Alice is noted to be repeating over and over, “I never saw that guy before” and “Why did he stab us?”

HOW DO YOU HANDLE THIS SITUATION?

Answer: Introduce yourself to Alice. State your name, role, and purpose for speaking with her. Ask her how she would like to be addressed. Ask open-ended questions to ascertain what triggered the crisis, such as “What happened?” Ask clarifying questions to pinpoint the nature of the crisis. Provide for her physical and emotional safety. Ensure that she is comfortable—for example, by offering a warm blanket, snack, or beverage. Provide a private and relaxing environment to help keep her calm and to enable her to gather her thoughts. Speak quietly in a soothing manner. Acknowledge her feelings of helplessness. Begin where she wants to begin. Help her verbalize emotions about, reactions to, and perceptions of the event. Establish rapport and show respect, empathy, and emotional support.

CRISIS INTERVENTION DISCUSSION REVIEW QUESTIONS

1. DISCUSS THE DEVELOPMENT PROCESS OF CRISIS STATES.

Answer: Patient is exposed to an overpowering precipitating stressor. All internal and external resources are activated to try to remove the stressor. When patient is unable to remove the overwhelming stressor, anxiety builds to a panic level.

2. IDENTIFY SOME COMMON BEHAVIORS IN A CRISIS STATE.

Answer: Agitation, tension, anxiety, crying, inability to think clearly, confusion, forgetfulness, disorganized thinking, poor impulse control, social withdrawal, increased psychomotor activity, perceptual changes, intense feelings, flashbacks, nightmares, and intrusive thoughts.

3. IDENTIFY TYPES OF CRISES.

4. **DISCUSS CAPLAN’S (1970) PHASES OF CRISIS INTERVENTION.**

**Answer:** Developing an alliance is about building trust and therapeutic rapport with the patient. Gathering information is finding out as much as possible about the precipitating event. Problem solving is helping the patient work through the crisis.

5. **DISCUSS THE IMPORTANCE OF EFFECTIVE COMMUNICATION WITH THE PATIENT IN CRISIS.**

**Answer:** Effective communication skills with patients in crisis are essential to enable you to develop a therapeutic alliance, gather the information needed, and help the patient solve problems to achieve a resolution.

**CRISIS INTERVENTION QUIZ**

1. Name the first phase of crisis intervention, where trust and rapport are built.
   - A. Developing the alliance
   - B. Gathering information
   - C. Problem solving
   - D. Resolution testing

   **Answer:** A. Developing the alliance

2. TRUE or FALSE: A crisis is a debilitating imbalance in internal equilibrium.

   **Answer:** TRUE

3. Traumatic stress can be caused by which of the following?
   - A. Welcome-home party
   - B. Sudden, devastating event
   - C. Change in class schedule
   - D. All of the above

   **Answer:** B. Sudden devastating event

4. Common crisis state behaviors include:
   - A. Tense, anxious, and emotionally distressed
   - B. Poor impulse control
   - C. Decline in overall cognitive functioning
   - D. All of the above

   **Answer:** D. All of the above
5. Effective communication skills with the patient in crisis include:
   A. Encourage verbalization
   B. Show empathy and respect
   C. Establish rapport
   D. A, B, and C
   E. None of the above

   Answer: D. A, B, and C

REFERENCES

“Mental health emergencies are severe disturbances in thoughts, mood and behavior requiring immediate therapeutic intervention in the emergency setting. Some types of common emergencies seen in the ED (emergency department) and clinical settings include suicide, alcohol/substance abuse disorders, psychotic disorders, and domestic violence” (Sadock, B. J., Sadock, V. A., & Ruiz, 2015).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 9.1. In the role play exercise, one participant assumes the role of the patient and the other the therapeutic healthcare worker. Have each participant discuss application of de-escalation techniques beneficial for managing patients experiencing mental health emergencies. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 9.1: MANAGING MENTAL HEALTH EMERGENCIES

Mr. Lewis is a 34-year-old male with a history of schizophrenia brought to the Emergency Department (ED) today by his parents for homicidal ideation. He recently broke up with his girlfriend and is experiencing outbursts of anger. While at home today, Mr. Lewis began hearing voices, and he has threatened to attack family members. When he arrives to the ED triage area, he yells, “Who are you, and what are you doing in my house?”

HOW DO YOU HANDLE THIS SITUATION?

Answer: Activate the safety-first buddy system, notify security, and initiate 1:1 monitoring in a single room for safety. Remove hazardous items from his reach. Reply with a calm, respectful, professional attitude, and give your name and reason for being in the room. Gently reorient Mr. Lewis to place and time, and reassure him that he is safe. Initiate verbal de-escalation with open-ended questions to promote verbalization and establish calming, therapeutic nurse-patient rapport.

MANAGING MENTAL HEALTH EMERGENCIES DISCUSSION REVIEW QUESTIONS

1. IDENTIFY THE THREE MOST COMMON MENTAL HEALTH EMERGENCIES SEEN IN EMERGENCY DEPARTMENTS.

Answer: Suicidal ideation, drug and alcohol abuse, and domestic violence.

2. DISCUSS WHY MENTAL HEALTH EMERGENCIES ARE INCREASING.

Answer: Aging general population, surge in alcohol and drug abuse, and increased stress in modern society.

3. DISCUSS SOME INDICATIONS OF POTENTIAL SUICIDE.

Answer: The patient describes feelings of overwhelming anxiety and suddenly gives away all valuable property and treasured belongings. The patient’s outlook suddenly seems “better” (this may indicate that the patient has made a decision and has the means for a successful suicide.) The patient begins telephoning loved ones to say goodbye or writes a suicide note.
4. DISCUSS THE IMPACT OF THE CAGE ALCOHOL ASSESSMENT QUESTIONNAIRE.

Answer: The CAGE questionnaire assesses the severity of a patient’s dependency on alcohol use.

5. DISCUSS A DE-ESCALATION TECHNIQUE THAT AIDS IN CALMING A VIOLENT PATIENT.

Answer: Verbal de-escalation: Encourage the patient to describe the precipitating events that caused the anger; verbally express anger instead of being physically aggressive toward others; and talk about issues and problems while you listen attentively, effectively diffusing the anger.

MANAGING MENTAL HEALTH EMERGENCIES QUIZ

1. When completing an emergency department assessment, it is vital to obtain pertinent information from what source or sources?
   A. Patient
   B. Family members
   C. Law enforcement (if present)
   D. All of the above

   Answer: D. All of the above

2. TRUE or FALSE: Mental health emergencies are considered to be any disturbance in thoughts, feelings, or actions for which immediate therapeutic intervention is needed.

   Answer: TRUE

3. The CAGE alcohol assessment acronym stands for what combination of words?
   A. Cut down, annoyed, guilty, and eye opener
   B. Cute, anxious, guileless, and everywhere
   C. Continuous, allowed, goal, and eventual
   D. All of the above

   Answer: A. Cut down, annoyed, guilty, and eye-opener

4. Which of these questions is/are included in the CAGE questionnaire assessment?
   A. Do you eat a lot in the morning?
   B. Do you feel comfortable about your drinking?
   C. Have you ever had to drink as an eye-opener first thing in the morning to steady your hands or nerves?
   D. All of the above

   Answer: C. Have you ever had to drink as an eye-opener first thing in the morning to steady your hands or nerves?
5. TRUE or FALSE: Individuals with mental health emergencies are evenly distributed according to sex.

Answer: TRUE

REFERENCE

The mental status assessment is a person-to-person interview conducted by nursing staff as part of a comprehensive physical and psychosocial assessment. Conducting this assessment involves asking questions and noting their answers, while also making visual observations.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 10.1. In the role play exercise, one participant assumes the role of the patient being admitted and the other the therapeutic caregiver. Have each participant discuss application of the mental status assessment beneficial in prevention of violence and aggression. Afterward, facilitate a group discussion evaluating the role play initiated.
Mr. Sawyer is a 43-year-old, well-nourished white male admitted voluntarily to the behavioral health facility for complaints of depressed mood lasting more than one year. He has a history of previous admissions for suicide attempts and was discharged two months ago with a diagnosis of major depression. Mr. Sawyer was previously stabilized on escitalopram 10 mg daily. After questioning, he states he stopped taking his escitalopram two weeks ago and has begun feeling “down” and depressed. Mr. Sawyer arrives to the facility from a local emergency room and appears to be sad and despondent.

**How will you complete the mental status admission assessment?**

**Answer:** The comprehensive admission mental status assessment in Figure 10.1 (page 40) is completed on Mr. Sawyer.

The “danger to self or others” section of the admission assessment in Figure 10.2 is utilized and completed from information received from Mr. Sawyer and objective information obtained from history, lab, and assessment data from the emergency department staff.

Mr. Sawyer was marked as a “yes” to the question of “danger to self or others,” as he verbally threatened self-harm and suicidal intent upon admission. He denied any homicidal thoughts. The suicide risk assessment template in Figure 10.3 was selected by the admission nurse to be completed on Mr. Sawyer because he had threatened self-harm.
Mr. Sawyer was then asked whether he had a plan to harm himself. He replied that he planned to obtain a weapon. Suicidal intent was assessed by asking whether he had feelings of an actual intent to harm himself or whether this was just a passive thought he would not act on. Mr. Sawyer replied that he did have actual intent to self-harm. He was then asked the final assessment question—whether he had any means by which to harm himself. All four sections of the suicide risk assessment were checked as positive for Mr. Sawyer, as he did have thoughts, a plan, intent, and a means to attempt self-harm. The degree of lethality of intent to harm was determined, documented, and reported to the psychiatrist/physician responsible for initiating precautions to prevent him from harming himself. Because Mr. Sawyer was at risk, the de-escalation plan assessment in Figure 10.4 was also completed during his admission to assess interventions, and the admission risk assessment (Figure 10.5, page 43) was completed to determine triggers for his self-harming behaviors that should be avoided until he stabilizes.

Do any of the following activities assist you to calm when under stress?
- Television
- Going for Walk
- Deep Breathing Exercises
- Puzzles/Games
- Time Alone/Quiet Time
- Physical Activity
- Speaking to Family, Friends, or Healthcare Staff
- Reading Book, Bible, or Magazine
- Taking Nap
- Music
- Warm Blanket
- Other

**FIGURE 10.4 A SAMPLE DE-ESCALATION PLAN ASSESSMENT**

**MENTAL STATUS ASSESSMENT DISCUSSION REVIEW QUESTIONS**

1. **DISCUSS THE MENTAL STATUS ASSESSMENT AND ITS IMPORTANCE AS A VITAL PART OF HOLISTIC NURSING CARE.**

**Answer:** The mental status assessment is a person-to-person interview conducted as part of a comprehensive physical and psychosocial assessment completed by nursing staff. The interview is completed using the question-and-answer method, with visual observations also recorded and documented into the patient’s written or electronic health record.
2. DISCUSS THE COMPONENTS OF THE MENTAL STATUS ASSESSMENT.

**Answer:** The components of the mental status assessment generally include physical appearance, orientation, behavior, attitude, affect, mood, thought processes, thought content, attention, concentration, insight into problems, memory, cognition/intellect, hallucinations, delusions, impulse control, danger to self or others, speech, motor activity, and judgment.

3. DISCUSS RISK ASSESSMENTS AND THEIR IMPORTANCE FOR SAFETY IN THE HEALTHCARE FACILITY.

**Answer:** Risk assessments are an essential part of mental health admissions as well as ongoing nursing assessment to provide safe, quality care and optimal patient recovery outcomes. Risk assessments evaluate whether the patient is a danger to self or others (suicide or homicide) and include de-escalation plans to prevent harming behaviors during a hospital stay. An admission risk assessment template is shown in Figure 10.5.

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Do any of the following render you emotionally upset, stressed, or agitated/violent?

- [ ] Touch
- [ ] Shouting/Loud Noise
- [ ] Physical Force
- [ ] Restraints
- [ ] Derogatory Names
- [ ] Television
- [ ] Uniforms
- [ ] Crying
- [ ] Anger
- [ ] Isolation
- [ ] Threats
- [ ] Other ____________________________

**FIGURE 10.5  ADMISSION RISK ASSESSMENT TEMPLATE**

The Joint Commission mandates that risk assessments be completed on all mental-health facility inpatients deemed at risk to themselves or others within 24 hours of admission to prevent harming behaviors. Early assessment, especially on admission, enables development of nursing interventions to negate any harmful intent directed toward self or others and promotes improvement in mental health.
4. DISCUSS ADMISSION DE-ESCALATION PLAN ASSESSMENT FOR HEALTHCARE VIOLENCE PREVENTION.

**Answer:** The best de-escalation interventions originate from the patient. Patient-selected de-escalation interventions are ascertained and documented during the admission risk assessment. The de-escalation plan assessment lists interventions to prevent escalation of harming behaviors and is completed as a permanent part of the admission mental status assessment of the electronic health record. Facility de-escalation plan assessments are developed based on Joint Commission standard requirements, which list criteria for de-escalation interventions to prevent violence or self-harm and assess triggers to violence and self-harm. A sample de-escalation plan assessment is shown in Figure 10.6.

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**FIGURE 10.6 A SAMPLE DE-ESCALATION PLAN ASSESSMENT**

Do any of the following activities assist you to calm when under stress?

- [ ] Television
- [ ] Going for Walk
- [ ] Deep Breathing Exercises
- [ ] Puzzles/Games
- [ ] Time Alone/ Quiet Time
- [ ] Physical Activity
- [ ] Speaking to Family, Friends, or Healthcare Staff
- [ ] Reading Book, Bible, or Magazine
- [ ] Taking Nap
- [ ] Music
- [ ] Warm Blanket
- [ ] Other ____________________________________

The purpose of the de-escalation plan assessment is to obtain vital information from patients on personal preferences for interventions that are most effective in calming them when agitated or depressed to prevent self-harm. The de-escalation assessment on violence triggers assists in identifying precursors to violence that may be diminished or eliminated from the environment to prevent episodes of violence or self-harm until patients become emotionally stable.

5. DISCUSS ASSESSMENT OF MOOD AS PART OF THE MENTAL STATUS ASSESSMENT.

**Answer:** Mood is defined as pervasive and sustained emotion that, in the extreme, can mark a person’s perception of the world. Descriptive terms for observed admission mental status assessment of mood include appropriate, apathetic, angry, anxious, depressed, dysphoric, elevated, euphoric, euthymic, fearful, irritable, and labile.
MENTAL STATUS ASSESSMENT QUIZ

1. When does violence prevention begin in a healthcare facility?
   A. First day of admission
   B. Within one week of admission
   C. One month after arrival
   D. All of the above
   Answer: A. First day of admission

2. TRUE or FALSE: The mental status assessment represents the single most important step in clinical evaluation of individuals who suffer from, or are suspected of having, mental disorders.
   Answer: TRUE

3. Hallucinations are assessed as:
   A. Auditory, visual, olfactory, tactile, or gustatory.
   B. Present, past, future
   C. Mild, moderate, severe
   D. All of the above
   Answer: A. Auditory, visual, olfactory, tactile, or gustatory.

4. Orientation is assessed as:
   A. Up, down, or sideways
   B. Round, flat, or square
   C. Person, place, time, situation
   D. None of the above
   Answer: C. Person, place, time, situation

5. TRUE or FALSE: Delusions are defined as beliefs that have no basis in reality and cannot be changed even in the face of evidence or logical reasoning.
   Answer: TRUE
Four prominent mental disorders frequently encountered in healthcare settings are schizophrenia, bipolar disorder, major depression, and panic disorder. It’s critical to use assessment and interventional techniques that are appropriate for each individual’s disorder to prevent escalation and ensure proper patient-centered care.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 11.1. In the role play exercise, one participant assumes the role of the patient and the other the therapeutic healthcare worker assisting with de-escalation. Have each participant discuss application of a de-escalation technique beneficial in calming persons with mental disorders. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 11.1: DE-ESCALATION OF PATIENTS WITH MENTAL DISORDERS (SCHIZOPHRENIA)

Mr. Haley is a 26-year-old man who was diagnosed with schizophrenia two years ago. After dropping out of high school, he remained restless and was never able to establish any type of meaningful life or vocation. Mr. Haley never attempted to make friends and remained alienated from his parents and siblings. He had frequent altercations with law enforcement and spent several months in the county jail. When Mr. Haley was released from jail, he refused to return home. Instead, he became homeless and was living on the streets. A concerned social worker from a nearby church found him sitting on a street corner, mumbling incoherently to himself and calling out to “voices” in his head. The social worker brought Mr. Haley to the emergency department to be evaluated.

Mr. Haley complains of seeing “demons” and makes little eye contact. He appears apathetic and answers questions with only “yes” and “no.” Mr. Haley’s hygiene is poor, and his clothing is tattered. His affect is blunted, and his speech is a soft monotone. Mr. Haley is responding strongly to internal stimuli.

HOW DO YOU HANDLE THIS SITUATION?

Answer: Assess Mr. Haley’s auditory and visual hallucinations, frequently observe his behavior, keep communication brief and simple, maintain a matter-of-fact yet friendly approach, and convey a calm attitude. Encourage him to verbalize any feelings of anxiety, tension, fear, or insecurity; encourage him to engage in physical exercise; and reorient him to reality. Quiet any noxious noises in the environment, remove any harmful objects from his environment for safety, avoid touching him without receiving permission first, and utilize a “buddy system” during de-escalation for safety.

DE-ESCALATION OF PATIENTS WITH MENTAL DISORDERS DISCUSSION REVIEW QUESTIONS

1. DISCUSS ASSESSMENT OF SCHIZOPHRENIA.

Answer: Schizophrenia is marked by disengagement from reality and is characterized by severe emotional, behavioral, and intellectual disturbances. Symptoms of schizophrenia include distorted perceptions of reality, diminished ability to think rationally, impaired emotional experiences, and social disengagement. Disorganized thoughts, negative mood states, impulsive behavior, and delusions and hallucinations are common in schizophrenia.
2. DISCUSS ASSESSMENT OF BIPOLAR DISORDER.

Answer: Bipolar disorder is characterized by cycles of intense mood swings. Patients alternate between a manic state, in which they experience an exhilarating euphoria, and a depressed state, in which they experience intense depression. Interspersed between these two states are periods of normal mood and behavior. Symptoms of bipolar disorder manic state include impulsivity, distractibility, grandiosity, hyperirritability, racing thoughts, insomnia, pressured speech, psychomotor agitation, and euphoria. Symptoms of bipolar depressed state include fatigue; inability to concentrate; sadness; thoughts of death; and feelings of hopelessness, worthlessness, emptiness, and guilt.

3. DESCRIBE DE-ESCALATION TECHNIQUES FOR BIPOLAR DISORDER.

Answer: De-escalation techniques for manic state include involving the patient in activities that require gross motor movements to dissipate the energy associated with mania. In the depressed state, give positive reinforcement that the depression will lift. Be alert also for any signs of suicidal ideation. Provide for physical needs such as hydration, nutrition, and adequate rest. Encourage self-care as well as personal hygiene.

Effective de-escalation techniques for bipolar disorder include speaking in a calm, clear, and self-confident manner. Provide emotional support and set realistic goals for appropriate behavior. Maintain a calm and quiet therapeutic environment with a low level of stimuli. Keep the environment free of hazards, allow the patient to speak, and listen attentively with a neutral professional attitude. Avoid power struggles, provide consistency in responses, and encourage the patient to engage in relaxation exercises.

4. DISCUSS ASSESSMENT AND DE-ESCALATION OF MAJOR DEPRESSIVE DISORDERS.

Answer: Major depressive disorder is a condition in which an individual experiences five or more prominent depressed symptoms that cause substantial distress and last at least two weeks.

Symptoms of major depressive disorder include depressed mood, fatigue, significant weight gain or loss, psychomotor agitation, feelings of worthlessness and guilt, indecisiveness, diminished interest or pleasure in activities, sleep disturbances such as insomnia or hypersomnia, diminished motor movements, and recurrent thoughts of death. Individuals with major depressive disorder can escalate to a suicide attempt. It is vital to intervene early with de-escalation techniques focused on preventing self-harming behaviors. De-escalation interventions for major depressive disorder include encouraging patients to socialize with friends or family to help lift their mood. Encourage them to take spiritual measures to feel better, such as reading the Bible or another religious text. Divert patients’ attention by suggesting they read a magazine, watch TV, or listen to music. Remove harmful objects from the environment (Boyd, 2008; Townsend, 2015). Teach problem-solving skills, and educate them on positive coping skills for managing stress, such as diaphragmatic breathing, meditation, and yoga.
5. DESCRIBE DE-ESCALATION TECHNIQUES FOR PANIC DISORDERS.

Answer: A panic disorder is a type of anxiety disorder characterized by recurring episodes of sudden and intense fear and panic-level anxiety. Early intervention can lead to quick and successful resolution of the anxiety and panic state. De-escalation techniques include remaining with the patient and giving reassurance of safety. Stay calm and serene—be a role model for patients to emulate. Speak clearly and directly, using as few words as possible. Avoid touching patients until therapeutic rapport is established; even then, ask permission first. Help them grasp the reality of their situation. Give directions one at a time, and make sure each direction is understood before proceeding to next one. Reduce environmental noise and dim lights for comfort. Provide a safe environment to protect patients and others from harm. Allow them to pace, and walk with them during de-escalation. Encourage patients to verbalize their feelings and express their emotions freely. Teach them relaxation techniques such as deep breathing, mental imagery, and visualization. Encourage patients to meditate and/or listen to calming music.

DE-ESCALATION OF MENTAL DISORDERS QUIZ

1. Types of anxiety levels are:
   A. High, moderate, and low
   B. Mild, moderate, severe, and panic
   C. Intensive, neutral, and panic
   D. None of the above

   Answer: B. Mild, moderate, severe, and panic

2. TRUE or FALSE: A panic disorder is defined as a type of anxiety disorder characterized by recurring episodes of sudden and intense fear and panic-level anxiety. Panic-attack episodes develop swiftly, for no apparent reason, and with no obvious precipitating event. They trigger severe physical and emotional reactions, including intense fear, apprehension, and feelings of impending doom.

   Answer: TRUE

3. In bipolar disorder, patients alternate between _____ and _____ states.
   A. Manic and depressed
   B. High and low
   C. Regular and normal
   D. All of the above

   Answer: A. Manic and depressed
4. Panic attack symptoms may include:
   A. Palpitations, sweating, trembling, shortness of breath
   B. Nausea, dizziness, chills, feeling hot
   C. Paresthesia, feelings of unreality, fear of losing control
   D. All of the above
   
   Answer: D. All of the above

5. TRUE or FALSE: Schizophrenia is a serious and pervasive lifelong mental disorder.
   
   Answer: TRUE

REFERENCES


Non-suicidal self-injury (NSSI) is the deliberate behavior that results in a self-inflicted injury and the destruction of body tissue without a conscious suicidal intent (American Psychiatric Association [APA], 2013).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 12.1. In the role play exercise, one participant assumes the role of the patient and the other the therapeutic healthcare worker assisting with de-escalation of the patient. Have each participant discuss an application of de-escalation pertinent to preventing self-injury. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 12.1: DE-ESCALATING PATIENTS EXHIBITING NON-SUICIDAL SELF-INJURY BEHAVIOR

Charles is a 20-year-old, single, well-nourished male arriving to the emergency department (ED) today for evaluation of superficial self-injury wounds to his right arm. Charles has a history of admissions for non-suicidal self-injury, usually superficial wounds to his torso and extremities. He works as a night security guard at a local manufacturing plant and began having urges to cut himself while on duty. Charles states the urge to self-harm was overwhelmingly strong. He took out his pocketknife and began making diagonal slices along his arm. After injuring his arm, Charles realized he needed help and phoned a coworker to relieve him on guard duty so he could go to the ED for treatment. Charles arrives with a flat affect and denies suicidal ideation, stating: “I don’t want to die. It’s just that cutting my arm makes the hurt I feel inside go away.”

Your role is that of a healthcare tech. You are assigned as a one-to-one sitter to keep Charles from injuring himself while he is being evaluated in the ED for admission.

HOW DO YOU DE-ESCALATE THIS PATIENT TO PREVENT HIM FROM ESCALATING TO SELF-INJURY BEHAVIOR?

Answer: Observe his behavior and ask Charles to report urges to self-injure. Encourage him to verbalize and to engage in physical exercise. Ask him to wear a loose rubber band around his wrist and snap it when he has an urge to self-harm. Have him hold an ice cube until it melts or suggest that he draw on his skin with a red felt-tip marker. Encourage him to write in a journal or create artwork. Turn on music. Give him praise and be a role model for appropriate behavior.

DE-ESCALATION OF PATIENTS EXHIBITING NON-SUICIDAL SELF-INJURY DISCUSSION REVIEW QUESTIONS

1. DISCUSS BEHAVIORS ASSOCIATED WITH NON-SUICIDAL SELF-INJURY.

Answer: Behaviors associated with non-suicidal self-injury include skin cutting or burning, biting, scratching, embedding objects, scalding, ingesting objects or toxins, picking, hair pulling, stabbing, head banging, striking, or evisceration of tissue.
2. EXPLAIN DIAGNOSTIC CRITERIA OF NON-SUICIDAL SELF-INJURY BEHAVIOR.

Answer: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes non-suicidal self-injury (NSSI) behavior as five or more days of intentional self-inflicted injury to one’s body likely to cause bleeding, bruising, or pain but without suicidal intent.

3. DISCUSS ORIGINS OF NON-SUICIDAL SELF-INJURY BEHAVIOR.

Answer: There is no one single origin of NSSI. Every individual self-injures for a different reason. However, self-injury is almost always used as a coping mechanism when individuals no longer feel they can resolve issues using standard problem-solving techniques (Alderman, 1997; Hawton et al., 2003; Klonsky, 2007). Some people self-injure to distract from emotional pain. For others, the behavior is a form of self-punishment or an expression of self-hate (APA, 2013). Other reasons for self-injury are to relieve dissociation symptoms or communicate emotional pain. The behavior can result from peer pressure or be a response to environmental triggers. Self-injury can also be an attempt to manipulate or control others.

4. DISCUSS ASSESSMENT OF NON-SUICIDAL SELF-INJURY BEHAVIOR.

Answer: Assessment of NSSI includes ascertaining when or in what circumstances the behavior typically occurs and what type of self-injury the patient most commonly inflicts, such as cutting or burning tissue. Also assessed are the area of the body most commonly self-injured, such as the face or limbs; the instruments used to inflict the injury; and individual coping skills to prevent self-injury.

5. DESCRIBE TYPES OF THERAPY FOR NON-SUICIDAL SELF-INJURY BEHAVIOR.

Answer: Therapies for NSSI include cognitive behavioral therapy and dialectical behavioral therapy. Cognitive behavioral therapy helps patients establish healthy ways of successfully managing stress without NSSI. Dialectical behavioral therapy uses behavioral and cognitive strategies to prevent self-injury; the focus of the therapy is to directly suppress urges to self-injure or to eliminate access to self-harming means.
DE-ESCALATION OF NON-SUICIDAL SELF-INJURY (NSSI) QUIZ

1. Common causes of non-suicidal self-injury (NSSI) include:
   A. Distract from emotional pain, punish self
   B. Get relief from dissociation, respond to peer pressure, manipulate others
   C. Communicate emotional pain, respond to environmental triggers
   D. All of the above

   Answer: D. All of the above

2. TRUE or FALSE: Non-suicidal self-injury is defined as deliberate behavior that results in a self-inflicted injury and the destruction of body tissue without conscious suicidal intent.

   Answer: TRUE

3. Non-suicidal self-injury is associated with:
   A. Borderline personality disorder, schizophrenia, eating disorders
   B. Post-traumatic stress disorder (PTSD), anxiety disorders
   C. Substance abuse disorders, depressive disorders
   D. All of the above

   Answer: D. All of the above

4. Beneficial techniques to calm urges and prevent self-injury include:
   A. Give a rubber band for wrist
   B. Encourage to verbalize feelings
   C. Encourage to write in journal
   D. All of the above

   Answer: D. All of the above

5. TRUE or FALSE: Non-suicidal self-injury is the same as suicidal ideation.

   Answer: FALSE

REFERENCES
Dementia is a syndrome characterized by generalized cognitive deterioration that impairs both social and vocational functioning (American Psychiatric Association [APA], 2013).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 13.1. In the role play exercise, one participant assumes the role of the patient with dementia and the other the therapeutic healthcare worker assisting with de-escalation. Have each participant discuss an application of de-escalation techniques beneficial in calming patients. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 13.1: DEMENTIA

George Watson is a 92-year-old man admitted to a healthcare facility with a diagnosis of dementia. Mr. Watson has been living with his daughter for several years. He had surgery four days ago for an open reduction of a fractured clavicle and has remained in the hospital for observation since then.

Mr. Watson is increasingly forgetful, confused, and suspicious, as well as gruff in his interactions with staff. He has begun wandering into other patients’ rooms and becomes agitated and aggressive when he is redirected to his room. Mr. Watson shakes his fist and shouts at staff members: “I am in my right room! All of you just leave!”

HOW DO YOU HANDLE THIS SITUATION?

Answer: Use a calm, caring approach with Mr. Watson. Spend time talking with him, and actively listen to develop therapeutic rapport. Allow him to verbalize issues and validate concerns. Be respectful and polite while redirecting him, use honorifics like “sir,” and employ simple courtesies such as saying “please” and “thank you.” Be flexible and accommodate his fluctuating physical and mental abilities to help stave off frustration and anger. Ask family members to bring in items from home to make the room more familiar to him. Display items related to his hobbies or interests to jog his memory. Keep his room well-lighted and noise levels down to reduce confusion. Provide a schedule of daily activities and procedures.

DE-ESCALATION OF PATIENTS WITH DEMENTIA DISCUSSION REVIEW QUESTIONS

1. DISCUSS THE WARNING SIGNS OF DEMENTIA.

Answer: Repeatedly asks same question, has difficulty organizing time, forgets to pay bills, misplaces objects, forgets to bathe, wears clothing inappropriate for the season, is apathetic, has trouble learning, forgets family names, forgets to take medications, misses medical appointments, loses math ability, forgets recent conversations or events.

2. DISCUSS EARLY SIGNS OF DEMENTIA.

Answer: Early signs include anxiety, depression, frustration, agitation, and suspicion.
3. DISCUSS SIGNS AND SYMPTOMS OF MID TO LATE STAGES OF DEMENTIA.

Answer: Exhibits poor awareness of safety, wears inappropriate layers of clothing, forgets to dress completely, gets lost in familiar areas (APA, 2013; National Institute for Health and Clinical Excellence [NICE], 2006). Has disturbances in sleep/wake cycle, loses weight, is unable to perform motor tasks, has diminished hand-eye coordination and gait, is unable to select correct words, has urinary and fecal incontinence, is disoriented to person, place, and time.

4. DISCUSS DE-ESCALATION TECHNIQUES FOR DEMENTIA.

Answer: Retain stable, consistent staff; introduce the patient to oncoming staff during shift changes; avoid changing the patient’s room or moving furniture; maintain a comforting, familiar environment; keep patient’s room well lighted; reduce noise levels; elevate head of bed for comfort and safety; explain all medical procedures step by step.

5. DESCRIBE GUIDELINES FOR DEMENTIA CARE.

Answer: Encourage patients to practice self-care, establish simple routines, use visual cues, organize activities and opportunities to socialize, provide positive reinforcement, promote physical exercise, and protect privacy and dignity.

DE-ESCALATION OF PATIENTS WITH DEMENTIA QUIZ

1. Effective techniques for de-escalation of patients with dementia include:
   - A. Aromatherapy
   - B. Comfort measures
   - C. Isometric exercise
   - D. Relaxation recordings
   - E. All of the above

   Answer: E. All of the above

2. TRUE or FALSE: Dementia is a syndrome characterized by generalized progressive cognitive deterioration impairing both social and vocational functioning. Dementia results in changes of behavior, perception, memory, problem-solving abilities, and judgment that interfere with normal daily life and functions.

   Answer: TRUE
3. To prevent dementia patients from being confused, it is important to provide:
   A. Clock and calendar
   B. Sundial
   C. Map
   D. All of the above

   Answer: A. Clock and calendar

4. Relaxation techniques beneficial in dementia care include:
   A. Deep breathing
   B. Meditation
   C. Progressive muscular relaxation
   D. All of the above

   Answer: D. All of the above

5. TRUE or FALSE: Reminiscence therapy is a technique for de-escalating dementia patients. This therapy involves asking people to think about a pleasant event in the past, such as their wedding day or birth of their first grandchild.

   Answer: TRUE

REFERENCES


Delirium is defined as a mental state characterized by a decreased ability to direct, focus, maintain, and shift attention (American Psychiatric Association [APA], 2013). The disturbance in cognitive impairment represents a change from usual mental function. Delirium usually develops over a short period of time, from a few hours to several days. The course of delirium is brief, from one week to one month. The severity of delirium may fluctuate throughout the day, depending on the underlying cause.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 14.1. In the role play exercise, one participant assumes the role of a patient with delirium and the other the therapeutic healthcare worker assisting with de-escalation. Have each participant discuss an application of de-escalation beneficial in delirium. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 14.1: DELIRIUM

Mrs. Alexander is a 74-year-old retired librarian arriving to the ED today for evaluation of possible overdose or allergic reaction to over-the-counter sleep medication. Mrs. Alexander is accompanied by her daughter Ellen, who was called to her mother’s home by a concerned neighbor who saw Mrs. Alexander walking barefoot outdoors in freezing temperatures, wearing only undergarments. When Ellen arrived at her mother’s home, her mother was very confused and agitated. She began repeating, “This new medication is making me sick” and pointed to an empty bottle. Ellen immediately brought her mother to the ED. During Mrs. Alexander’s medical evaluation, she is confused and disoriented to person, place, time, and situation. She is shouting, agitated, and hallucinating.

HOW DO YOU HANDLE THIS SITUATION?

Answer: Approach Mrs. Alexander from the front. Keep things short and simple and choices to a minimum. Praise her for cooperation, ask open-ended questions, explain procedures, and don’t over-promise. Speak to her on an adult level, validate her feelings, and gently redirect and reorient her to reality. Reassure her that she is safe. Play music and engage her in reminiscence therapy. Stay alert and remove safety hazards to protect her from injury.

DE-ESCALATION OF PATIENTS WITH DELIRIUM DISCUSSION REVIEW QUESTIONS

1. DISCUSS ORIGINS OF DELIRIUM.

Answer: Delirium is a common psychiatric illness among medically compromised patients. Often, it is a direct physiological consequence of another medical condition, such as hypoxia from increased intracranial pressure, blood loss, arteriosclerosis, chronic obstructive pulmonary disease, congestive heart failure, hepatic encephalopathy, or acute respiratory tract infection. Delirium may also result from substance intoxication or withdrawal, exposure to a toxin, or a combination of these factors. The illness is usually reversible, especially with early recognition and treatment—as well as treatment of the underlying medical condition causing the delirium (APA, 2013).
2. EXPLAIN ASSESSMENT OF PATIENTS WITH DELIRIUM.

**Answer:** Assess for fluctuating levels of consciousness, disorientation, severe confusion, impaired ability to reason, impaired ability to engage in goal-directed behavior, impaired attention span, alternating states of hyperactivity and hypersomnolence, disturbance in sleep-wake cycle, vivid dreams, nightmares, intense fear, intense anxiety, impaired short-term memory, language disturbances, perceptual disturbances, and aggressive or combative behavior.

3. DISCUSS PRACTICES TO PREVENT ESCALATION OF PATIENTS WITH DELIRIUM.

**Answer:** Build a positive relationship with patients. Tell them their condition is short-term and will improve. Encourage self-care and independence. Educate patients on coping skills, and encourage them to interact with others. Identify interests and skills, and provide a schedule of daily activities and procedures. Provide a calm environment, and prepare patients for potentially stressful situations.

4. DESCRIBE DE-ESCALATION TECHNIQUES FOR DELIRIUM.

**Answer:** Validate patients’ feelings, divert attention, engage in reminiscence therapy, reorient patients, reassure them they are safe, discourage delusional thinking, and play music.

5. DISCUSS WAYS TO ENSURE SAFETY OF PATIENTS WITH DELIRIUM.

**Answer:** Ensure patients have access to needed sensory aids, such as eyeglasses and hearing aids, and ambulatory aids, such as a walker. Stay alert for possible need for one-to-one observation for safety. Place patients near the nurses station to allow for more frequent observation. Remove safety hazards such as pathway obstacles, spills on the floor, open flames, or inadequate lighting. During periods of confusion, protect patients from injury by assisting with ambulation to prevent falls, providing a well-lighted room, and aiding with activities of daily living.
DE-ESCALATION OF PATIENTS WITH DELIRIUM

QUIZ

1. Medical conditions associated with hypoxia that may cause delirium include:
   A. Subdural hematoma
   B. Stroke
   C. Malignancies
   D. All of the above
   
   Answer: D. All of the above

2. TRUE or FALSE: Delirium is usually reversible, especially with early recognition.
   
   Answer: TRUE

3. Techniques to restore optimal memory function include:
   A. Place a calendar and clock within sight.
   B. Hang seasonal decorations in patient’s room.
   C. Display photos of loved ones.
   D. All of the above
   
   Answer: D. All of the above

4. Guidelines for communicating to calm those experiencing delirium include:
   A. Ask open-ended questions.
   B. Keep communication short and simple.
   C. Explain procedures.
   D. All of the above
   
   Answer: D. All of the above

5. TRUE or FALSE: Involving the patient’s family members or significant other in care can help the patient cope with the stressors associated with delirium.
   
   Answer: TRUE

REFERENCES

“Difficult” truly has no single definition. Every healthcare worker has a different description of the characteristics of the difficult patient. But there is one common trait of difficult patients that all healthcare staff agree on: They consume more of healthcare workers’ time than other patients and more time than normally necessary for any task or assistance.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 15.1. In the role play exercise, one participant assumes the role of the difficult patient and the other the therapeutic healthcare worker assisting with de-escalation. Have each participant discuss an application of de-escalation techniques beneficial for the difficult patient. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 15.1: DE-ESCALATION OF DIFFICULT PATIENTS

Mr. Mitchell is a 56-year-old man who is a newly admitted inpatient at a healthcare facility. He is diabetic and suffers from bipolar disorder. Mr. Mitchell had a stroke two years ago and is unable to clearly voice his needs and feelings. He is often angry and frustrated by his inability to be clearly understood. At times, Mr. Mitchell gets angry and becomes physically aggressive with staff, often without warning.

Today, Mr. Mitchell's physician has informed him that his request to be discharged has been denied. He shakes his fists and begins shouting obscenities at the physician.

HOW DO YOU HANDLE THIS SITUATION?

Answer: Speak to Mr. Mitchell with a steady, calm, and pleasant voice. Greet him with his full name, or use an honorific such as “sir.” Introduce yourself and offer availability to talk. Gently redirect and educate him. Encourage him to perform relaxation exercises. Offer choices and encourage him to verbalize his feelings. Don’t rush him. Acknowledge that you are listening. Ask simple questions that require only short answers. Ensure the environment is quiet and calming. Speak to him at eye level to show respect. Present information one item at a time. Clarify with him if you do not clearly understand any communication or issue. Repeat information several times. Show empathy and understanding appropriate to the situation.

DE-ESCALATION OF DIFFICULT PATIENTS DISCUSSION REVIEW QUESTIONS

1. DISCUSS ORIGINS OF DIFFICULT BEHAVIOR.

Answer: There are many origins for difficult behavior: pain, stress, grief, fear, feelings of hopelessness or worthlessness, poor coping skills, tendency to bottle up emotions until the person explodes, and adverse reaction to medication. Research indicates that patient care groups closely associated with difficult behavior are patients with chronic pain, complex care issues, substance abuse, chronic fatigue syndrome, obsessive-compulsive disorder, or addictive disorders (Brunero, Fairbrother, Lee, & Davis, 2007; Macdonald, 2003). Mental disorders associated with difficult behavior include psychotic disorders, personality disorders, chronic depression, and schizoid and schizotypal conditions.
2. **EXPLAIN ASSESSMENT OF DIFFICULT PATIENTS.**

*Answer:* When assessing a difficult patient, be alert for behavioral signs or body language that may indicate escalation. These might include agitated motion, loud or profane speech, clenched jaw or fist, flushed face, enlarged eyes, flared nostrils, rapid breathing, verbal threats, demands for attention, and encroachment on another’s personal space.

3. **DISCUSS TECHNIQUES TO PREVENT ESCALATION OF DIFFICULT PATIENTS.**

*Answer:* Greet patients with their full name or use an honorific. Introduce yourself and offer availability to talk. Encourage patients to verbalize their issues, and don’t rush them when they are speaking. Acknowledge that you are listening. Clarify to make sure you understand what patients are saying.

4. **DISCUSS EFFECTIVE DE-ESCALATION PRACTICES FOR DIFFICULT PATIENTS.**

*Answer:* Encourage patients to talk about their issues. As you converse with them, reflect empathy and understanding. Offer to help them resolve their issue or problem.

Encourage patients to perform relaxation exercises. Redirect difficult patients. Give them choices, and avoid arguing or engaging in power struggles. Calmly but firmly indicate your expectations regarding their behavior, and make them aware of boundaries (Fishkind, 2002). This should be a nonconfrontational and respectful discussion. Educate patients on correct behavior expected.

5. **DESCRIBE BEHAVIORS COMMONLY ASSOCIATED WITH DIFFICULT PATIENTS.**

*Answer:* Behaviors commonly associated with difficult patients include demanding special privileges that others do not receive, making insulting remarks toward others, acting helpless, and failing to cooperate with requests. Difficult patients may play staff against each other to cause tension among the team, fail to comply with treatment regimens, and use threats rather than requests to meet their needs. They may hold up the flow of work with unnecessary demands and generally will require more time for their care than other patients.
DE-ESCALATION OF DIFFICULT PATIENTS QUIZ

1. Characteristics of the difficult patient include:
   A. Demanding, deceptive, aggressive, violent
   B. Dependent, threatening, disinhibited, poor care adherence
   C. Moody, bullying, rude, manipulative
   D. All of the above
   Answer: D. All of the above

2. TRUE or FALSE: Difficult behavior originates from one source.
   Answer: FALSE

3. Guidelines for communicating with difficult patients include:
   A. Never talk about patients like they are not present.
   B. Speak in a normal tone of voice.
   C. Avoid carrying on more than one conversation at a time.
   D. All of the above
   E. None of the above
   Answer: D. All of the above

4. Effective de-escalation techniques for difficult patients include:
   A. Encourage relaxation techniques.
   B. Educate patient.
   C. Offer choices.
   D. All of the above
   Answer: D. All of the above

5. TRUE or FALSE: Communicating with difficult patients can be a challenge. Still, nurses must make every effort to do so in a therapeutic manner. This requires critical thinking, patience, and diplomacy. The therapeutic healthcare professional must maintain self-control—always role-modeling calm and appropriate behavior for the patient.
   Answer: TRUE

REFERENCES
Anger is defined as a strong, unpleasant, and uncomfortable emotional response to an unwanted provocation resulting from injury, mistreatment, or opposition (Schiraldi & Kerr, 2002).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 16.1. In the role play exercise, one participant assumes the role of the angry patient and the other the therapeutic healthcare worker assisting with de-escalation. Have each participant discuss techniques beneficial in de-escalation of the angry patient. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 16.1: DE-ESCALATION OF ANGRY PATIENT

Gary is a 23-year-old male inpatient in a medical facility for cancer treatment. He is married with three children and works as an optical assistant. Today, Gary is pacing back and forth in his room, pounding his fist into his palm in an angry rage. This is unusual because earlier, Gary was in a good mood and was very cooperative. The nurse approaches Gary to try to de-escalate the situation.

HOW DO YOU HANDLE THIS SITUATION?

Answer: Ask Gary open-ended questions to encourage him to verbalize and ventilate his anger. Listen to him when he speaks. Show empathy and understanding and provide emotional support. Offer to help. Don’t make promises you cannot keep. Develop therapeutic rapport.

DE-ESCALATION OF ANGRY PATIENTS DISCUSSION REVIEW QUESTIONS

1. DISCUSS ORIGINS OF ANGER.

Answer: Theories for the origins of anger include psychoanalytic, biologic, behavioral, and sociocultural. Psychoanalytic theory suggests that anger is instinctual. Biologic theory proposes that biological factors such as neurochemical triggers, developmental deficits, anoxia, malnutrition, and tumors cause or contribute to anger (Edwards & Loprinzi, 2018). According to behavioral theory, anger is a learned response to a specific stimulus. Sociocultural theory suggests that anger originates from cultural influences of high-pressure, high-stress, competitive, and success-oriented environments (Boyd, 2008).

2. EXAMINE ASSESSMENT OF ANGRY PATIENTS.

Answer: A nurse’s primary goal when assessing anger is to identify any function or secondary gain that anger, frustration, or rage may provide for the individual, as well as other causes. In addition to assessing whether the patient is expressing anger, the nurse should determine whether the patient has difficulty regulating or controlling anger when it arises.
3. DISCUSS DE-ESCALATION TECHNIQUES FOR ANGRY PATIENTS.

**Answer:** Encourage patients to take a time out to calm themselves. Ask open-ended questions that encourage them to verbalize issues precipitating the anger, rather than act out aggressively. Educate patients on how to calm themselves and control their anger, such as by counting to 10. Teach calming measures such as meditation, journal writing, yoga, mental imagery, and progressive muscular relaxation.

4. EXPLAIN THE PATTERN OF ANGER.

**Answer:** Anger begins with a stressor. After the stressor is felt, anxiety and tension build. With no outlet available, anger begins. As anger builds, physiologic changes occur: The heart races, the blood pressure rises, and the stomach becomes tight or upset. As the intensity of anger builds, the person may experience the fight-or-flight instinct.

5. DESCRIBE TYPES OF EXPRESSIONS OF ANGER.

**Answer:** There are two types of expressions of anger: negative and positive. Negative expressions of anger include self-destructive anger and uncontrolled rage that is harmful to everyone. In contrast, positive expressions of anger, such as airing grievances so they can be addressed immediately and resolved, are constructive.

**DE-ESCALATION OF ANGRY PATIENTS QUIZ**

1. Theories of the origins of anger include:
   A. Psychoanalytic, biologic, behavioral, sociocultural
   B. Psychological, maternal, human, relational
   C. Cultural, physical, biological, normal
   D. All of the above

   **Answer:** A. Psychoanalytic, biologic, behavioral, sociocultural

2. TRUE or FALSE: Anger is defined as a strong, unpleasant, and uncomfortable emotional response to an unwanted provocation resulting from injury, mistreatment, or opposition.

   **Answer:** TRUE

3. De-escalation techniques for anger include:
   A. Meditation, yoga, journal writing, thinking before acting
   B. Reduce stress, count to 10, listen to music, walk or jog
   C. Verbalize issues, forgive, engage in positive self-talk
   D. All of the above

   **Answer:** D. All of the above
4. Stressors that can spark anger include:
   A. Personal conflicts, medical health issues, unpleasant events or memories
   B. Financial problems, work-related stress, emotional stress
   C. Excessive use of alcohol or substance abuse, perceived threats to way of life
   D. All of the above
   
   Answer: D. All of the above

5. TRUE or FALSE: Lewin’s (1951) change model stages are preparing for change, changing, and maintaining change.
   
   Answer: TRUE

REFERENCES


Safety is preventing harm such as physical injury and ensuring the welfare of the staff, patients, and everyone in the area (Chabora, Judge-Gorny, & Grogan, 2003).
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 17.1. In the role play exercise, one participant assumes the role of the agitated patient and the other the therapeutic healthcare worker assisting with de-escalation. Have each participant discuss an application of safety beneficial in de-escalation. Afterward, facilitate a group discussion evaluating the role play initiated.

CASE STUDY 17.1: STAYING SAFE DURING DE-ESCALATION

Mr. Lewis is a 53-year-old man with an acquired brain injury from a motor vehicle accident. Since undergoing surgery to replace his right hip, he has developed an unsteady gait. Mr. Lewis is irritable, labile, demanding, and confused. He requires assistance with all activities of daily living (ADLs).

The nurse on duty, Samantha, hears Mr. Lewis shouting in his room that he needs a nurse to take him to the bathroom. She immediately walks into his room and sees Mr. Lewis attempting to get out of bed without assistance. He begins waving his arms wildly and cursing Samantha.

HOW DOES SAMANTHA HANDLE THIS SITUATION SAFELY?

Answer: Samantha recognizes that Mr. Lewis is agitated and requires immediate de-escalation. She activates the “buddy system” by asking a second nurse, Oliver, to stand watch. Oliver stands calmly in the doorway. He does not speak to or touch Mr. Lewis as Samantha gently redirects him. This prevents Mr. Lewis from being overwhelmed by too much communication. Samantha begins speaking to him in a slow, calm, and direct manner while standing outside his personal space. As she does, Oliver continues to stand quietly in the doorway, ready to assist Samantha if needed for safety.

She continues to speak to Mr. Lewis in a calm and pleasant manner. She asks his permission to assist him and explains that she will gladly help him to the bathroom. Mr. Lewis agrees to walk to the bathroom with her assistance and begins to calm down. After he is finished in the bathroom, Samantha suggests that he rest for a while in the quiet of his room. Through it all, Oliver stands quietly in the doorway, poised to help.

Later, Samantha returns to Mr. Lewis’s room. She sits down with him to discuss his earlier anger. During the conversation, Mr. Lewis explains that his anger arose because he thought he would not be able to get to the bathroom in time. He then states that all he needs is for someone to come by every so often to help him go to the bathroom, and he will not become so angry again. Samantha agrees to place Mr. Lewis on a two-hour toileting schedule and informs the healthcare team of the change for continuity of care. By intervening early with de-escalation techniques and therapeutic communication skills, Samantha has found a way to prevent future episodes with Mr. Lewis, which improves unit safety.
STAYING SAFE DURING DE-ESCALATION DISCUSSION REVIEW QUESTIONS

1. DISCUSS DOOR SAFETY PROTOCOLS PERTINENT TO DE-ESCALATION.

Answer: Mental health nurses are taught to stay close to the door in case they need to exit the area quickly for safety reasons. This technique is useful for all healthcare nurses and staff. Pay attention when a patient gets between you and the exit. If a patient who is agitated or aggressive or exhibits threatening behavior positions himself between you and the door, it could mean you are in imminent physical danger. If the patient escalates to violence, you could be cornered or trapped, unable to get past the patient to escape. When entering the room of an inpatient on a mental health unit, keep a clear path to the exit available for safety (Stokowski, 2007) and stay close to the door if you can.

2. EXPLAIN BODY LANGUAGE AND ITS IMPORTANCE IN DE-ESCALATION.

Answer: With respect to safety, it’s important for healthcare staff to take special care to avoid using body language that may be interpreted as intimidating or threatening. When interacting with agitated patients, it is important to move slowly, avoid sudden or abrupt movements, and approach them in clear view. Maintain eye contact to show respect. Speak to patients at eye level, which also conveys respect. Don’t back them into a corner or crowd them. Don’t touch them, as that could be interpreted as an aggressive gesture. Don’t turn your back on agitated patients. This prevents you from monitoring them visually and places you in a vulnerable position. Keep your hands free and in the open. Don’t cross your arms because that may convey hostility. Adopt the supportive stance with palms facing upward. This stance is a nonverbal way to convey that you are not a threat. It communicates kindness, courtesy, and respect in the interaction, which assists with de-escalation.

3. DISCUSS SAFETY ASPECTS OF HAIR AND ACCESSORIES.

Answer: If you have long hair, avoid wearing it loose. Aggressive patients could easily injure you by pulling your hair or tangling their fingers into it to hold you in place (Stokowski, 2007). It is safer to keep hair short or wear it in a bun. Dangle earrings are also a danger because they can be easily grabbed and pulled. If earrings must be worn, post earrings without dangles are best. Neck jewelry is best avoided due to the risk for strangulation. Heavy neck chains are particularly dangerous. For your safety, it’s best to leave this type of jewelry at home.

In addition to neck jewelry, badge cords and stethoscopes worn around the neck pose a risk for strangulation. Most hospitals are providing nurses with breakaway lanyard badge cords for safety reasons. As for stethoscopes, it’s best to carry yours in your hand or pocket rather than wearing it around your neck. In addition, discard any pens, sharp objects, or cords before approaching an agitated patient to de-escalate.
4. DISCUSS THE IMPORTANCE OF PERSONAL SPACE IN DE-ESCALATION.

Answer: When conversing with agitated or aggressive patients, maintain a safe distance and stay well outside their personal space (Gately & Stabb, 2005; Hilgers, 2003). For most people, personal space consists of a 3- to 4-foot buffer. When patients are behaving in an aggressive manner, you should give them more room. This ensures you will be beyond their reach and away from danger in the event they turn violent (Paterson, Leadbetter, & McComish, 1997). It also gives patients room to breathe and calm themselves.

5. DISCUSS THE “BUDDY SYSTEM” FOR SAFETY.

Answer: A staff member should never be left alone with an agitated patient. For safety reasons, have a coworker stand by, or ask a security guard for assistance. Know where your coworkers are and watch out for each other. When faced with an aggressive patient, use the buddy system. It’s good practice to develop silent hand signals to summon help from your buddy when faced with an aggressive patient. For example, you might hold up two fingers in the “peace” or “victory” sign. Panic buttons and body alarms are also used in healthcare facilities to summon support from coworkers.

STAYING SAFE DURING DE-ESCALATION QUIZ

1. Door safety protocols include:
   A. Stay next to an exit door for safety.
   B. Clear an unobstructed path to exit door.
   C. Avoid getting cornered without an exit.
   D. All of the above

   Answer: D. All of the above

2. TRUE or FALSE: The de-escalation process is focused on safety.

   Answer: TRUE

3. Paying attention to your surroundings for safety includes visually scanning the perimeter for:
   A. Objects that could be turned into harmful projectiles
   B. Unobstructed exit routes
   C. Available coworkers in case you need help
   D. All of the above

   Answer: D. All of the above
4. Which of these objects is a hazard to wear when de-escalating an agitated patient?
   A. Breakaway lanyard
   B. Long dangle earrings
   C. Heavy gold neck chain
   D. Both B and C
   E. All of the above
   Answer: D. Both B and C

5. TRUE or FALSE: It is vital that staff be available for therapeutic intervention and de-escalation at healthcare facilities, even during shift changes.
   Answer: TRUE

REFERENCES
Debriefing is defined as an official questioning session after an event—an interview in which the patient, nurse, and any other staff or individuals present for the de-escalation event are asked to report on the incident.
ROLE PLAY GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing the scenario in Case Study 18.1. In the role play exercise, one participant plays the role of the agitated patient and the other the therapeutic healthcare worker assisting with de-escalation. Have the remaining individuals in the group document their observations of this de-escalation encounter, and compare their answers to the correct de-escalation documentation that follows Case Study 18.1. Afterward, facilitate a group discussion evaluating documentation of the case study de-escalation encounter.

CASE STUDY 18.1: DE-ESCALATION

Susan is a 42-year-old woman admitted to the medical unit today for evaluation of an inflamed lower lumbar cyst. She is a stockbroker who has reluctantly taken time off from her busy office to have the troublesome cyst evaluated and possibly removed. Susan was served a lunch today containing cold food. It is the last straw for her, and she stomps angrily into the unit hallway, waving her fists overhead and shouting loudly, “My lunch is cold; how do you expect me to eat this?” and “I am going to throw it in your face and make you eat it.”

Anita, the charge nurse, immediately walks over to de-escalate Susan while two nurses stand nearby for safety. Anita apologizes for the cold food and states she will bring a hot tray straight to her room. She encourages Susan to talk. Susan admits she is under a great deal of stress and misses her work. She calms down, and Anita gently redirects her back to her room. Susan later apologizes to the staff for her earlier outburst.

HOW DO YOU DOCUMENT THIS DE-ESCALATION ENCOUNTER?

**Answer:** Document the date and time of the de-escalation encounter; an objective description of Susan’s behavior and verbalization, using quotes if possible; the specific de-escalation techniques used and any other care provided; and a detailed description of Susan’s response to these interactions. Provide a step-by-step description of your contacts with her during the incident. Also document the names and times when individuals—for example, the attending physician or the psychiatrist on duty—were notified of her behavior and what their response was (Mohr, 2009). Document what time the notified individual arrived to see her and whether the de-escalation intervention was successful.

DE-ESCALATION DOCUMENTATION—SUSAN

01/21/2020, 11:15 a.m.
Patient seen walking in hallway, agitated and loudly verbally disruptive. Patient is shouting at nurses and waving her fists over her head, yelling, “My lunch is cold; how do you expect me to eat this?” and “I am going to throw it in your face and make you eat it.”
—A. Nurse, RN

01/21/2020, 11:16 a.m.
Verbal de-escalation initiated x 10 minutes. Patient redirected to lower voice and return to her room. De-escalation successful. Patient now calm and cooperative, returned voluntarily to her room. Duplicate warm food tray ordered.
—A. Nurse, RN
AFTER THE INCIDENT DISCUSSION REVIEW QUESTIONS

1. DISCUSS DEBRIEFING WITH THE PATIENT AND STAFF.

**Answer:** Debriefing is an official questioning session after an event—an interview in which the patient, nurse, and any other staff present for the de-escalation event are asked to report on the incident. Debriefing is a teaching moment that identifies opportunities for performance improvement. It demonstrates how to work with individuals who are engaging in inappropriate behavior to help them improve and regain self-control. The goal of debriefing is to prevent problems, rather than to place blame.

The debriefing focus is on addressing what can be learned from the incident and how staff and patients can use that knowledge to prevent a recurrence. It provides an opportunity to review techniques used and to consider lessons learned. Debriefing identifies what can be changed to avoid an aggressive episode in the future.

2. EXPLAIN THERAPEUTIC INTERDISCIPLINARY TEAM COMMUNICATION.

**Answer:** Communication among interdisciplinary healthcare personnel is very important. It allows for consistency in care and early de-escalation interventions. Reporting and documenting are essential forms of interdisciplinary communication. When staff observe that a de-escalation technique is effective in calming the patient, this information should be placed in the unit report to inform other members of the healthcare team so they can use the same technique. It is vital that interdisciplinary communication be accurate, clear, concise, and consistent.
3. DISCUSS REPORTING A DE-ESCALATION ENCOUNTER.

Answer: De-escalation encounters are reported to the provider on duty, such as a physician, psychiatrist, or nurse practitioner. The nurse manager or supervisor on duty should also be notified. In addition, information about the intervention should be included in the unit report to inform nurses arriving on duty. Some facilities may even require that an incident report be completed.

4. EXPLAIN DOCUMENTATION OF A DE-ESCALATION ENCOUNTER.

Answer: Documentation of a de-escalation encounter includes the date and time, an objective description of the patient’s behavior, and verbalizations (in quotes if possible). Specific de-escalation techniques utilized, the effectiveness of the intervention, and a description of contacts with the patient during the incident are included. Also documented are the names of persons notified of the patient’s behavior, what time they were notified, what time they arrived to the unit, and what their responses were.

5. IDENTIFY WHO PARTICIPATES IN A DEBRIEFING.

Answer: Patient or patients involved and nurses or other healthcare staff present during the de-escalation encounter.

AFTER THE INCIDENT QUIZ

1. Debriefings provide an opportunity to:
   A. Review clinical data
   B. Revise the treatment plan
   C. Identify performance improvement
   D. All of the above

Answer: D. All of the above

2. TRUE or FALSE: A PRN medication is not considered to be a de-escalation intervention.

Answer: TRUE

3. Interdisciplinary communication must be:
   A. Clear and concise
   B. Accurate and consistent
   C. Irrelevant
   D. All of the above
   E. Both A and B

Answer: E. Both A and B
4. Documentation of de-escalation must always be:
   A. Accurate
   B. Ambiguous
   C. Unnecessary
   D. All of the above

   Answer: A. Accurate

5. TRUE or FALSE: The inclusion of the patient’s perspective in any debriefing is critical.

   Answer: TRUE

REFERENCE

In any clinical setting, the environment can either create or mitigate stress. Healthcare environments that are caring and healing do the latter—decrease stress and create a supportive space for healing by inducing calm and serenity and inhibiting agitation (Sakallars, MacAllister, Voss, Smith, & Jonas, 2015).
GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing Scenario 19.1. In the group discussion exercise, each participant analyzes the scenario and looks at different ways the environment can be improved. Facilitate a group discussion about the scenario in which each participant discusses different techniques and interventions to transform the environment into a calming, caring, and healing environment beneficial in de-escalation.

CASE STUDY 19.1: CREATING A CALMING, CARING, AND HEALING ENVIRONMENT

The new 10-bed inpatient unit for geriatric mental health is located on the top floor of a large medical facility. The unit is a large square area with a nurses station facing a dayroom and a hallway leading to 10 inpatient rooms. There are no windows on this inpatient unit, as it is located in the interior section of a large hospital. The stark, bare walls of the unit—painted dull gray—are dismal and dreary. There are no inpatient groups or activities for the patients because the nurse manager never had time to hire a therapist for the unit. Staff members lack training in de-escalation and are known to be bad tempered and rude to patients, family members, and interdisciplinary staff arriving on the unit. Violence rates are high, and discharged patient evaluations of the unit are the lowest in the hospital.

HOW CAN YOU IMPROVE THIS UNIT TO MAKE IT A CALMING, CARING, AND HEALING ENVIRONMENT?

Answer: Paint walls a cheerful color, or place murals of nature scenes on the bare walls. On other walls, place calming words such as “Peace” and “Hope” or quotes from famous people on peace and recovery. Paintings of pleasant nature scenes under unbreakable Plexiglass covers can also be helpful in creating a healing environment.

Educate nursing staff in de-escalation and therapeutic communication techniques monthly until patient evaluations and care improve—then change the frequency to twice a year. Place colorful educational posters focused on de-escalation on the unit wall, with pictures showing staff having pleasant, healthy interactions with smiling patients. Hire a therapist to teach inpatient groups and activities. Provide patients a schedule of the new groups and activities. Educate and encourage staff in compassion, kindness, and civility toward patients, coworkers, and interdisciplinary staff. Every act of kindness is a moment of caring to create a healing environment.

CREATING A CALMING, CARING, AND HEALING ENVIRONMENT DISCUSSION REVIEW QUESTIONS

1. DISCUSS ELEMENTS OF THE HEALTHCARE ENVIRONMENT RELATED TO CARING AND HEALING.

Answer: A healthcare environment that is caring and healing decreases stress and creates a supportive space for healing by inducing calm and serenity and inhibiting agitation as well as aggression (Sakallaris, MacAllister, Voss, Smith, & Jonas, 2015). Research indicates a caring-healing environment
has a positive impact on both physical and psychological outcomes (Goudin, Kiecolt-Glaser, Malarkey, & Glaser, 2007). The healthcare environment includes the physical layout and design of the patient’s room, hallway, unit, and facility—but it also includes every interaction between staff and patients as well as interactions with interdisciplinary staff (Keegan, 1994; Kreitzer, 2015). Environments that are truly healing and caring are created when interpersonal relationships between caregivers and those they serve are built on mutual respect and a shared commitment to holistic healing (Felgen, 2003).

2. DESCRIE CREATION OF A CALMING, CARING, AND HEALING HEALTHCARE ENVIRONMENT.

Answer: Nature themes are a key element of caring and healing environments. Views of or access to nature areas such as gardens and fountains are shown to improve cohesion of mind, body, and spirit (Sakallaris et al., 2015). Calming messages in an environment help to create a caring, healing environment. Patients consider a healthcare environment to be healing when they have a positive relationship with caregivers; receive care that attends to body, emotions, mind, and spirit; have a relationship with their caregiver; and are actively involved in decisions regarding their own care.

3. EXPLAIN HOW TO FOSTER CARING AND HEALING HEALTHCARE THROUGH STAFF INTERACTIONS.

Answer: An intentional caring relationship between a caregiver and patient (and the family) is the core of the healing environment. This relationship requires compassion and empathy. Caring presence is another requirement. A caring presence is the foundation of the therapeutic relationship and the cornerstone of a caring-healing environment. It enables healthcare staff to establish trust and rapport with patients and family members (Felgen, 2004; Keegan, 1994; Trout, 2011). A caring presence can also help prevent escalation and assist with de-escalation. Caring is most often expressed in what are called “moments of caring,” which occur in the interpersonal interactions between staff and patients, families, visitors, or colleagues (Felgen, 2004). These shared moments can make the difference in a patient’s opinion of the healthcare staff and the facility. Every person interacting with the patient in positive moments of caring creates a calming, caring, and healing environment.

4. DISCUSS CARING ASSUMPTIONS OF MADELEINE LEININGER’S THEORY OF CULTURE CARE DIVERSITY AND UNIVERSALITY.

Answer: Madeleine Leininger (2006) developed the theory of culture care: diversity and universality, which expressed five theoretical assumptions about caring. The first is that caring is essential for human growth and survival—and eventually to face death. Second, there can be no healing without caring. The third assumption is that expressions of caring differ among world cultures. Fourth, therapeutic nursing care can occur only when cultural care values, expressions, and practices are known as well as understood. The last theoretical assumption of Leininger’s theory is that nursing is a transcultural care profession and discipline. These caring assumptions form the basis of universal culture caring in Leininger’s theory.
5. DISCUSS MODELS OF CARING BEHAVIOR.

Answer: Models for caring behavior include the key components of care of the self, care of each other, and care for patients. Care of self is nurturing yourself. Care of each other is displaying kindness toward other nurses and healthcare staff. Care for patients is our privilege of providing quality care to our patients.

CREATING A CALMING, CARING, AND HEALING ENVIRONMENT QUIZ

1. Caring assumptions that form the basis of Madeleine Leininger’s universal culture caring are:
   A. Respect
   B. Comfort
   C. Presence
   D. All of the above
   E. None of the above

   Answer: D. All of the above

2. TRUE or FALSE: Compassion is an awareness and understanding of one’s relationship to all living beings.

   Answer: TRUE

3. Collegial relationships are characterized by:
   A. Trust
   B. Mutual respect
   C. Support
   D. Open, honest communication
   E. All of the above

   Answer: E. All of the above

4. Fill in the blank: A ______ presence is the foundation of the therapeutic nurse-patient relationship.
   A. Existential
   B. Caring
   C. Temporary
   D. All of the above

   Answer: B. Caring

5. TRUE or FALSE: Empathy is the ability to step into another’s shoes.

   Answer: TRUE
REFERENCES


A major strategy to prevent violence in healthcare facilities is to establish an organized healthcare violence prevention plan focused on the patient, caregiver, and environment. This plan must account for common causes of violence, include specific techniques to prevent violence, and cite interventional strategies to de-escalate violent situations when they occur. Developing a plan and de-escalation educational program to combat violence in a healthcare setting helps foster a therapeutic environment and promotes safety, health, wellness, and optimal recovery outcomes.
GROUP DISCUSSION ACTIVITY

Engage two or more individuals in a group discussion reviewing Scenario 20.1. In the exercise, each participant analyzes the scenario and develops a violence prevention plan targeting the suggested problem areas related to patient risk factors, environmental factors, and caregiver factors to develop an organized plan to prevent violence in the healthcare setting. Facilitate a group discussion evaluating the different types of plans developed and their impact on preventing violence to improve healthcare safety.

CASE STUDY 20.1: DEVELOPING A HEALTHCARE VIOLENCE PREVENTION PLAN

A medical hospital has a large, 15-bed inpatient unit with complex patient, environmental, and caregiver risk factors. The most common risk factors for patients include mental instability, delusions, poor impulse control, agitation, disorganized thoughts, and overwhelming stress. The environmental factors are excessive noise, crowded inpatient facilities, lack of privacy, an ever-changing population, chaos during shift changes, high influx of new admissions requiring acute and complex medical care, lack of dignity, and lack of structure. Caregiver factors include lack of education and training in de-escalation. The newly hired staff lacks therapeutic communication skills, and frequent power struggles occur with patients. The new hires also lack familiarity with the unit.

Develop an organized violence prevention plan based on Scenario 20.1, targeting the problem areas related to patient risk factors, environmental factors, and caregiver factors to prevent violence in the healthcare setting.

ANSWER:

TABLE 20.1  A SAMPLE VIOLENCE PREVENTION PLAN

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<thead>
<tr>
<th>Risk Factors</th>
<th>Violence Prevention Interventions and Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Domain</td>
<td></td>
</tr>
<tr>
<td>Mental instability</td>
<td>1. Perform a mental status and risk assessment on admission per facility protocol.</td>
</tr>
<tr>
<td>Delusions</td>
<td>2. Intervene early and de-escalate.</td>
</tr>
<tr>
<td>Poor impulse control</td>
<td>3. Provide patient education (inpatient groups).</td>
</tr>
<tr>
<td>Agitation</td>
<td>4. Provide peer mentors for support.</td>
</tr>
<tr>
<td>Disorganized thoughts</td>
<td>5. Provide patient with other outlets for stress and anxiety, such as exercising (if physically able), listening to music, talking to a friend or staff member, or attending support groups.</td>
</tr>
<tr>
<td>Overwhelming stress</td>
<td>6. Allow for direct communication with caregivers and provider.</td>
</tr>
<tr>
<td></td>
<td>7. Partner with the patient in treatment planning to focus on identifying and meeting individual healthcare needs.</td>
</tr>
<tr>
<td></td>
<td>8. Offer PRN (when needed) medication if psychological de-escalation efforts fail and dangerous escalation persists.</td>
</tr>
<tr>
<td></td>
<td>9. Practice one-to-one observation (if called for).</td>
</tr>
<tr>
<td></td>
<td>10. Help the patient identify incentives for optimal behavioral improvement.</td>
</tr>
<tr>
<td></td>
<td>11. Emphasize the patient’s strengths and the hope of recovery.</td>
</tr>
</tbody>
</table>
### Environmental Domain

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive noise</td>
<td>Create a calming, caring and healing physical environment:</td>
</tr>
<tr>
<td>Crowding</td>
<td>• Foster a calm therapeutic environment.</td>
</tr>
<tr>
<td>Lack of privacy</td>
<td>• Design the ward for optimal observation.</td>
</tr>
<tr>
<td>Changing population</td>
<td>• Mitigate risks during times of transition.</td>
</tr>
<tr>
<td>Chaos during shift changes</td>
<td>• Display educational posters around unit to teach healthy and</td>
</tr>
<tr>
<td>New admissions requiring acute and complex medical care</td>
<td>appropriate behaviors.</td>
</tr>
<tr>
<td>Lack of dignity</td>
<td>• Stagger shifts so they overlap to maximize staff availability.</td>
</tr>
<tr>
<td>Lack of structure</td>
<td>• Have staff dine with patients.</td>
</tr>
<tr>
<td></td>
<td>• Provide activity schedules.</td>
</tr>
<tr>
<td></td>
<td>• Conduct safety searches for contraband or hazardous items</td>
</tr>
<tr>
<td></td>
<td>(mental health inpatient facilities only).</td>
</tr>
<tr>
<td></td>
<td>• Decrease or eliminate long lines.</td>
</tr>
<tr>
<td></td>
<td>• Control access to entrances and exits.</td>
</tr>
<tr>
<td></td>
<td>• Put on calming music or television programs.</td>
</tr>
<tr>
<td></td>
<td>• Implement recovery education groups.</td>
</tr>
<tr>
<td></td>
<td>• Organize meaningful therapeutic activities.</td>
</tr>
<tr>
<td></td>
<td>• Foster a predictable, safe, orderly, and respectful environment.</td>
</tr>
<tr>
<td></td>
<td>13. Keep environmental stimulation to a minimum.</td>
</tr>
<tr>
<td>Surveys</td>
<td></td>
</tr>
</tbody>
</table>

### Caregiver Domain

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of education and training in de-escalation</td>
<td>14. Perform a mental health learning needs assessment on caregivers to</td>
</tr>
<tr>
<td>Lack of therapeutic communication skills</td>
<td>identify gaps for educational and competency development in the</td>
</tr>
<tr>
<td>Frequent power struggles</td>
<td>following areas:</td>
</tr>
<tr>
<td>Lack of familiarity to unit</td>
<td>• De-escalation training</td>
</tr>
<tr>
<td></td>
<td>• Violence-prevention training</td>
</tr>
<tr>
<td></td>
<td>• Crisis-intervention training</td>
</tr>
<tr>
<td></td>
<td>• Management of aggressive behavior</td>
</tr>
<tr>
<td></td>
<td>• Conflict-resolution training</td>
</tr>
<tr>
<td></td>
<td>• CPI or PMDB training</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic communication training</td>
</tr>
<tr>
<td></td>
<td>• Interpersonal skill development</td>
</tr>
<tr>
<td></td>
<td>• Early intervention and de-escalation</td>
</tr>
<tr>
<td></td>
<td>15. Offer availability to talk and encourage verbalization of issues</td>
</tr>
<tr>
<td></td>
<td>and precipitating events.</td>
</tr>
<tr>
<td></td>
<td>16. Engage in therapeutic communication by doing the following:</td>
</tr>
<tr>
<td></td>
<td>• Introduce yourself.</td>
</tr>
<tr>
<td></td>
<td>• Call the patient by the proper name (e.g., Mr. or Mrs. Smith, or</td>
</tr>
<tr>
<td></td>
<td>sir or ma’am).</td>
</tr>
<tr>
<td></td>
<td>• Use active listening.</td>
</tr>
<tr>
<td></td>
<td>• Acknowledge and validate the person’s feelings.</td>
</tr>
<tr>
<td></td>
<td>• Show respect in your words and interactions.</td>
</tr>
</tbody>
</table>

continues
TABLE 20.1  A SAMPLE VIOLENCE PREVENTION PLAN (CONT.)

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Violence Prevention Interventions and Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Domain</td>
<td></td>
</tr>
<tr>
<td>17. Remain calm and non-confrontational. Do the following:</td>
<td></td>
</tr>
<tr>
<td>• Don’t argue and never shout.</td>
<td></td>
</tr>
<tr>
<td>• Model calmness.</td>
<td></td>
</tr>
<tr>
<td>• Use nonthreatening body language.</td>
<td></td>
</tr>
<tr>
<td>18. Debrief.</td>
<td></td>
</tr>
<tr>
<td>19. Spend time observing and assessing patients in the therapeutic milieu.</td>
<td></td>
</tr>
<tr>
<td>20. Be reliable and consistent.</td>
<td></td>
</tr>
<tr>
<td>21. Allow patients adequate personal space and minimize personal risk.</td>
<td></td>
</tr>
<tr>
<td>For example, keep doors open, wear short hair and post earrings (rather than ones that dangle), and avoid wearing objects around the neck.</td>
<td></td>
</tr>
<tr>
<td>22. Use acuity-based staffing.</td>
<td></td>
</tr>
</tbody>
</table>

DEVELOPING A HEALTHCARE VIOLENCE PREVENTION PLAN DISCUSSION REVIEW QUESTIONS

1. DISCUSS PATIENT RISK FACTORS FOR VIOLENCE.

Answer: Patient risk factors include mental instability, delusions, command hallucinations with violent content, history of violence, poor impulse control, irritability, attention-seeking behavior, agitated state, disorganized thought processes, and violation of personal space.

2. RELATE DE-ESCALATION INTERVENTIONS FOR PATIENT VIOLENCE RISK FACTORS.

Answer: Interventions for patient violence risk factors include the following: Perform mental status and risk assessment as per facility protocol on admission, intervene and de-escalate early, provide patient education, provide peer mentors for patient support, provide patients with other outlets for stress and anxiety, allow for direct communication with caregivers and providers, collaborate with patients in treatment planning, emphasize patients’ strengths and the hope of recovery, identify incentives for optimal improvement, and practice one-to-one observation (if called for).
3. DISCUSS ENVIRONMENTAL RISK FACTORS FOR VIOLENCE.

**Answer:** Environmental risk factors for violence include excessive motion; excessive noxious noise; lack of stimulation; ever-changing inpatient population; unpredictable behavior of others; crowded inpatient facilities; locked unit; chaos during shift change; lack of privacy; lack of personal space; high influx of new admissions requiring acute, complex medical care; lack of dignity; lack of freedom and autonomy; and lack of structure.

4. DESCRIBE DE-ESCALATION INTERVENTIONS FOR ENVIRONMENTAL RISK FACTORS.

**Answer:** De-escalation interventions for environmental risk factors include the following: Create a caring and healing physical environment; foster a calm, therapeutic environment; decrease environmental stimulation; design the ward for optimal observation; mitigate risks during times of transition; stagger shifts so they overlap; be flexible; reduce agitation during mealtimes; promote peer advocates as mentors and facilitators of patient-centered care; organize meaningful therapeutic activities; implement recovery education groups; schedule activities and groups during days, evenings, weekends, and shift changes; post activity schedules; display educational posters around the unit; be consistent; conduct safety searches upon admission (in mental health facilities only); decrease or eliminate long lines; control access to entrances and exits; put on calming music or television programs; foster a predictive, safe, orderly, and respectful environment; minimize sensory deficits; keep environmental stimulation to a minimum; and debrief after violent episodes.

5. EXAMINE CAREGIVER RISK FACTORS.

**Answer:** Caregiver risk factors include staff education levels, lack of training in de-escalation and aggression management, staff skills and work experience, lack of familiarity with the venue of care, lack of familiarity with the patient, rigidity of routines, physical setting of limits, lack of therapeutic communication skills among nurses, aloof or uncaring manner, lack of emotional and physical availability, power struggles, nurse overreaction, and too many demands placed on a patient.

6. LIST DE-ESCALATION INTERVENTIONS FOR CAREGIVER RISK FACTORS.

**Answer:** De-escalation interventions for caregiver risk factors include the following: Assess caregiver mental health learning needs, provide training in interpersonal skills, boost communication skills, provide annual training on violence prevention, provide education on maintaining reliability and consistency in therapeutic care, use acuity-based staffing, intervene early, manage aggressive behavior, offer availability, knock first and introduce yourself, use honorifics, encourage verbalization of issues and precipitating events, listen, acknowledge and validate the individual’s feelings, show respect, don’t argue, never shout, model calm, use nonthreatening body language, spend more time observing and assessing patients in the therapeutic milieu, be reliable and consistent, allow patients adequate personal space, be familiar with safety standards, and minimize personal risk.
DEVELOPING A HEALTHCARE VIOLENCE PREVENTION PLAN QUIZ

1. The holistic approach for effective violence prevention plans is focused on:
   A. Patient
   B. Provider
   C. Patient, environment, and caregiver
   D. None of the above
   Answer: C. Patient, environment, and caregiver

2. TRUE or FALSE: Early de-escalation intervention is key, before the patient loses complete control. This breaks the cycle of aggression and prevents violence.
   Answer: TRUE

3. Fill in the blank: To prevent violence in healthcare, you need a ________.
   A. Category
   B. Plan
   C. Collage
   D. All of the above
   Answer: B. Plan

4. Fill in the blank: ____________ targeting the causes of inpatient violence will greatly improve safety for patients, staff, and everyone else in the healthcare environment.
   A. High energy
   B. Low resilience
   C. Educational programs
   D. All of the above
   Answer: C. Educational programs

5. TRUE or FALSE: Healthcare facilities that offer a calm, safe, therapeutic environment; maintain safe staffing levels; and offer meaningful therapy (including group therapy) are likely to experience fewer episodes of violence and promote optimal recovery outcomes.
   Answer: TRUE