Crisis Intervention Training Program

Health Care Manual

Safe Management Group

Caring for your safety

Participants Workbook, *7TH Edition*

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PLEASE READ CAREFULLY

As a participant in the Crisis Intervention Training Program, you will be involved in practicing intervention strategies. Please be advised that some of these methods involve physical contact and may include risk of injury. It is important that you follow the exact directions of your Instructor.

Safe Management Group Inc. makes no warranty or representation that the skills, techniques, and methods taught in this program comply with all local laws, rules, regulations, and ordinances which may be applicable to persons utilizing same. Safe Management Group Inc.'s Physical Intervention Techniques should be used in a manner which is in compliance with local laws and regulations. Safe Management Group Inc. assumes no liability whatsoever for any bodily injury, loss, damage or any related claims caused by the misuse or incorrect application of the skills, techniques, and methods taught in this program, as a result of any undisclosed medical condition or by illegal or inappropriate use of same, whether or not such injury, loss, or damage is foreseeable.

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Creating and Maintaining Safe Environments

Introduction

Our Mission

Our mission is guided by our core principle, "Caring for your safety." We will provide comprehensive, effective and proven training programs and consultation services to promote patient and community safety through dignity and respect.

Overview

Safe Management Group's Crisis Intervention Training Program was initially developed in 1990 for staff working in agencies that serviced adults with developmental disabilities. It was developed by psychologists, behaviour analysts/ therapists, and physical intervention specialists to address the unique needs and challenges posed by patients with unsafe aggressive/violent behaviour. Clinical experience suggested that a high proportion of this behaviour was predictable and, therefore, potentially preventable if appropriate information was obtained and used within a behavioural management system. Experience also suggested that more extensive physical intervention techniques were often required to safely manage the aggressive behaviour that was more commonly seen. All of our training programs were designed to integrate behavioural management principles, strategies and techniques with new, improved state-of-the-art physical intervention techniques. These techniques reflect the diverse professional skills of the design team and the unique needs of the patient, while emphasizing the least restrictive, least intrusive philosophy of care.

Our Crisis Intervention Training Program has been recognized by the Ministry of Children, Community and Social Services since 2003 for agencies serving children, youth and adults with developmental disabilities. Safe Management continues to build partnerships with organizations, community partners, and Ministries in pursuit of maintaining and caring for all levels of safety.

Research

Safe Management Group Inc. continues to research the effectiveness of its training programs and the outcome measures are published. We have partnered with various organizations on these endeavours and will continue to do so.

Initial studies suggest that Safe Management's Crisis Intervention Training, together with Trauma Informed Care, the Trauma Recovery Model, and other system interventions, makes a positive difference to both staff and the people they serve. These interventions reduce the need for both physical and mechanical restraints, lower staff injuries, and reduce behaviour crises.

Our ongoing study of the effectiveness of our online vs. classroom training has shown that online training is highly successful in teaching course content, with a statistically significant increase in knowledge to a score of 82% correct.

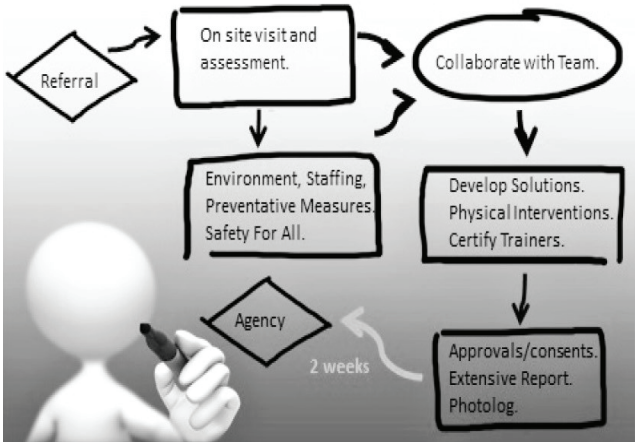
Aspects of the Program

Safe Management Group's Crisis Intervention Training Program involves training in Risk Management, Behavioural Management, Relationship Management, and Aggression Management, as well as physical intervention skills. Patients whose aggressive behaviours require more complex physical intervention techniques than are offered in the Crisis Intervention Training require an "Individualized Specialized Consultation" by Safe Management Group personnel. This consultation ensures that the techniques are properly designed for the patient, the staff, and the specific environment. The consultation also ensures that specific professions (behavioural therapists and psychologists) are involved to assist in the preventative behavioural management programming and environmental enhancement, which helps to ensure that the techniques are used optimally for the patient.

Safe Management Group's Crisis Intervention Training Program provides staff and instructor training. Accordingly, there are two manuals that accompany the program; a Training Workbook/Reference Manual for all training participants, and an Instructor's Guide/ Advanced Manual for instructors. Knowledge and performance testing of all participants is conducted by the Instructors using specially designed Safe Management Group tools. Trainer skills are monitored by Safe Management Group on an annual basis.

Specialized Consultations result in a Individualized Specialized Consultation Report that includes an updated behavioural and environmental assessment of the patient and "photolog" of individualized physical intervention techniques. Designated and trained Instructors provide staff training and monitoring of the staff's skills in the techniques identified in the consultation report.

Patient Specialized Consultation Process



Basis of Program

Our philosophical basis for all of our training programs involves integrating principles, strategies, and techniques from the areas of:

Ministry Regulations

Staff are employed by organizations from different Ministries – e.g., Education, Health Care, Corrections, and Children, Community and Social Services. Each Ministry has its own regulations and Policies/Procedures regulating the use of physical restraint. A review of these policies indicates a common emphasis on the following:

- Preventing restraints.
- Using restraints only as a last resort and only for reducing imminent risk to a patient.
- Using restraints only if approved by various regulated health professionals, agency/organization administrators, and by parents/ legal guardians/ substitute decision makers.

SMG believes that the MCCSS document Services and Supports to Promote the Social Inclusions of Persons with Developmental Disabilities Act (2008) contains the most extensively developed standards for the regulation and use of restraints, especially when integrated with preventative behavioural programming. The new Quality Assurance Measures set out the criteria for the implementation, training and monitoring of all Behaviour Support Plans. All patients with challenging behaviours who are supported by a community agency require a Behaviour Support Plan. The Behaviour Support plan must outline a functional assessment and positive programming interventions, seek out least intrusive effective strategies and be approved and monitored by a Psychologist or BCBA Behaviour Analyst. Safe Management Group's Crisis Intervention training incorporates each of these areas recognizing its importance in the prevention and management of challenging behaviours. Safe Management Group's Crisis Intervention Training program has been approved since 2003 by the Ministry of Children, Community and Social Service for use with children, youth and adults. A further review was conducted in 2011/12; which recognized Safe Management's program was in compliance with O. Reg 299, S18 (3c8). Regulation 299/10 sets out the qualifications of those who can approve behaviour support plans that incorporate the use of intrusive strategies.

Accordingly, approval is required by a Psychologist, Psychological Associate, a Physician, a Psychiatrist or Behaviour Analyst certified by the Behaviour Analyst Certification Boards. Safe Management Group's Crisis Intervention Training incorporates each of these areas, recognizing their importance in the prevention and management of challenging behaviours.

When "Ministry" guidelines are mentioned it is the MCCSS Behavioural Standards and associated guidelines to which we are referring as a good standard. Safe Management Group Inc. makes no warranty or representation that the skills, techniques and methods taught in this program comply with all local laws, rules, regulations and ordinances that may be applicable to persons utilizing same. Safe Management does attempt to stay apprised of various Ministry regulations and standards and modify programs to address such changes. Safe Management Group Inc.'s Physical Intervention Techniques should be used in a manner that is in compliance with local laws and regulations.

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Organization of Program

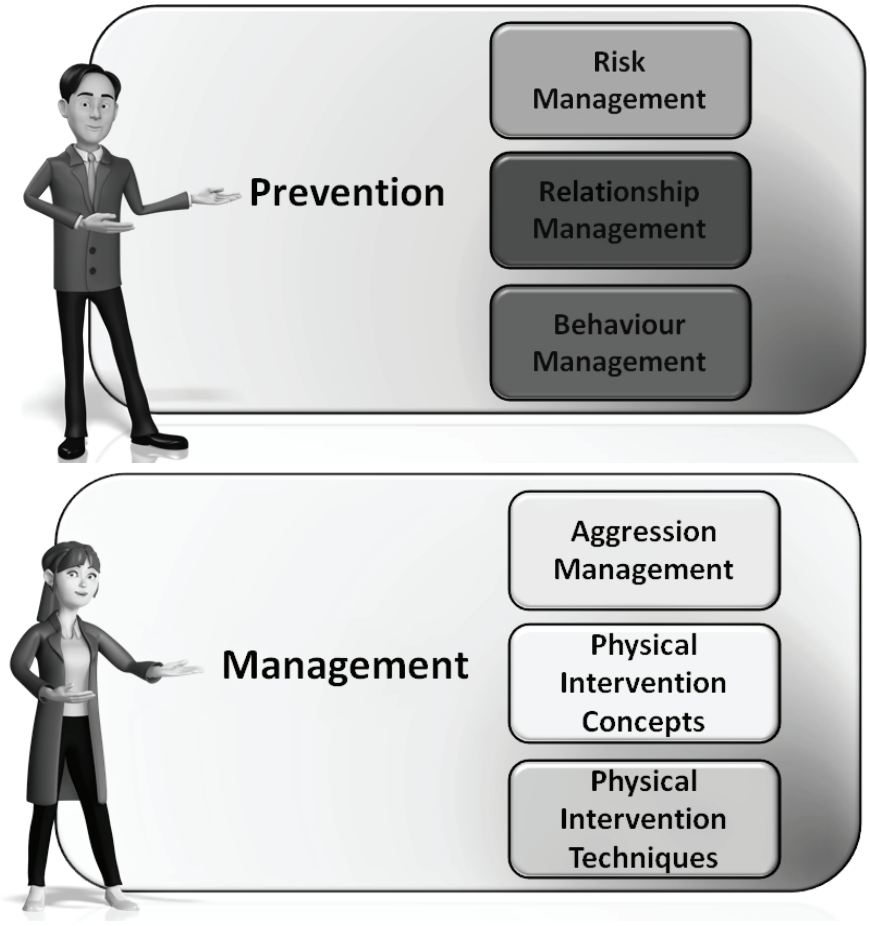
The approach of our Training Program relies heavily on the distinction between **"Prevention"** and **"Management"** of risky behaviours. **"Prevention"** involves those techniques that reduce the future probability of an aggressive incident.

"Management" refers to all those techniques used at the time of an incident to reduce its intensity and/or duration. Safe Management Group places strong emphasis on prevention; however, when Management Strategies are required, we focus on the least intrusive strategies, while maintaining safety for both the patient and staff at all times.

This training introduces the distinction between **"Predictable"** and **"Unpredictable"** behavioural crises, with the idea that Predictable crises involve a higher degree of responsibility and liability for adequate prevention.

The typical concept of risk is broadened to include the idea of "Organizational/Agency Risk", which allows for the consideration of Ministry and Organization Policies in a truly comprehensive "Crisis Intervention" Training Program.

Management Techniques are outlined in the Aggression Management and Physical Intervention Concepts. A four-level model of escalating aggression, manifested in three domains of patient functioning, is introduced as a basis for developing individualized comprehensive management plans.



Specialized Training Programs

Safe Management recognizes the unique needs of patients. As such, we have developed a number of certified training programs to address these needs.

Developmental/Adult
- Adult - Day/Residential Services
- Families/Caregivers

Children with Autism Spectrum Disorders/Complex Needs
- Children's Aid
- Autism Services
- Children/Youth - Day/Residential Services
- Families/Caregivers

Health Care
- Community Health Care/In-Out Individual Treatment Centres
- Long Term Care
- Mental Health/Forensics
- Acquired Brain Injury

Education
- Colleges
- School Boards
- Universities

Community
- Municipal Services
- Emergency Response Services
- Security/Corrections
- Private Service Sector

Elderly Care
- Long Term Care
- Medically Fragile

Why SMG Training?

This training system was developed for people providing services to populations who may, on occasion, demonstrate aggressive/violent behaviours. Recognizing that such aggressions can result from cognitive ability, previous history and/or current circumstances, implementers of the program need to match their responses to the particular incidents and intervene with timely, practiced and specific techniques that ultimately:

- Ensure the safety of everyone involved.
- Support the organization's Policies & Procedures.
- Adhere to all relevant Government Acts.

The approach is straightforward:

- Whenever possible, strive to **prevent aggressive incidents** before they occur.
- If prevention is impossible, **intervene with the least intrusive measures** possible.
- If physical intervention is absolutely necessary, employ the Safe Management techniques, which are firmly based in sound physical intervention principles, so that **response is swift and effective.**

This course is designed with the following in mind:

- Staff must match their responses to each patient by carefully profiling and taking into consideration critical elements of each patient's response style and history.

- Some patient's are not verbal; nor can they respond to verbal intervention. Thus, gestures, environmental cues and reference to established routines all need to be considered when establishing a framework for intervention.

- It is rare for patients with significant cognitive, developmental, or neurological deficits to respond in a logical, rational way to verbal intervention. Therefore, the course covers a spectrum of communication techniques.

- Staff may be frightened and frustrated when dealing with repeated incidents of aggression. Knowledge of early interventions can significantly decrease anxiety and frustration.

By participating in realistic case studies and directed role-plays, you will:

- Gain greater understanding of underlying causes of aggressive/violent behaviour.
- Be able to recognize escalating behaviour patterns and how to intervene.
- Become more attuned to verbal, physical and environmental cues.
- Expand your problem-solving abilities in the areas of awareness and physical intervention skills.

The Recovery Model

The Recovery Model of Care in mental health services emphasizes recovery and hopefulness for the future of those with significant mental health issues. It has been heavily influenced by the recent Positive Psychology and older Humanistic traditions in Clinical Psychology. Six key principles govern this approach; some similar to the Trauma-Informed Care Model, such as Hope, Security, Supportive Relationships, Empowerment and Inclusion, Coping Strategies, and Meaning.

Safe Management Group Inc.'s comprehensive Crisis Intervention Day One Program was designed to teach principles, strategies and techniques related directly to the Recovery Model, including the humanistic-inspired 7 Principles of Relationship Management, the Behaviour Profiling of patient's, Environmental Risk Management, and the Collaborative Problem Solving approach to Verbal De-Escalation.

Hope	• Effective Prevention engenders hope • Collaborative Problem Solving teaches self-control
Secure	• Environment Risk Management • Behaviour Profile • Minimally painful interventions
Supportive Relationships	• Relationship Management • Behavioural Profile
Empowerment & Inclusion	• Collaborative Problem Solving model of De-escalation • Behaviour Profile
Coping Strategies	• Collaborative Problem Solving teaches Anger Management Skills • Behaviour Profile
Meaning	• Collaborative Problem Solving encourages uncovering underlying problems

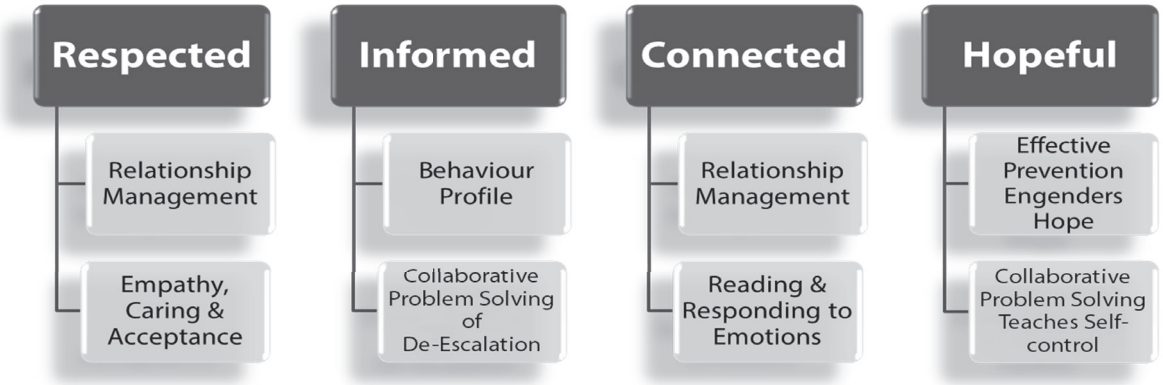
Trauma Informed Care

As noted on the SAMHSA website "Trauma-Informed Care is an approach used to engage people with histories of trauma. It recognizes the presence of trauma symptoms and acknowledges the role that trauma can play in people's lives." This approach has become important in all mental health services areas, and the goal has been to create trauma-informed environments that facilitate mental health and recovery.

Safe Management Group Inc.'s comprehensive Crisis Intervention Program focuses on strategies and techniques related directly to the objectives of creating TIEs; including the humanistic-inspired 7 principles of Relationship Management, the Behaviour Profiling of patients, the Collaborative Problem Solving approach to Verbal De-Escalation and the skills of Reading and Responding to Emotions.

A Trauma-Informed Environment (TIE) includes four critical elements:

1. Respect for the patient
2. Being Informed about the patient's individuality and uniqueness
3. Experiencing Connectedness with caregivers
4. Supporting Hopefulness about the future and recovery



RISK MANAGEMENT

Section One

This section of the course outlines the Risk Management concepts of Safe Management Group Inc.

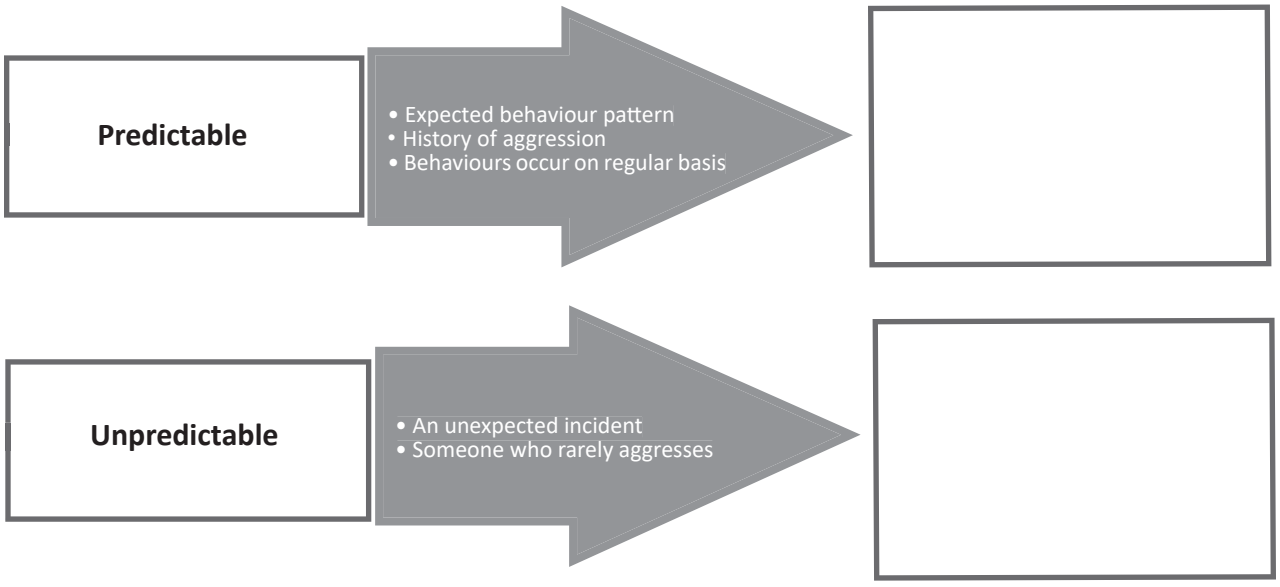
At the end of this section, participants should be able to:

1. Appropriately plan for Predictable Crises and respond accordingly to Unpredictable Crises.
2. Identify and mitigate risks that occur between patient and staff, staff and patient and between staff.
3. Understand the legislative criteria for the use of intrusive protocols (physical interventions).
4. Understand how system issues influence aggression within agencies.
5. Identify and mitigate risks associated with the physical environment.
6. Understand the relationship between personal stress management and managing aggression in others.

Behavioural Crisis

Definition: *An escalating episode of emotional upsets involving anger and verbal threats, which may lead to dangerous situations of self-abuse, environmental destructiveness and/or physical aggression towards staff and peers.*

There are two types of Behavioural Crises:



Effective Prevention of Behaviour Crises

Action:

- Plan for "Predictable" crises, but know how to respond in "Unpredictable" behavioural crises.

Principles of Effective Prevention:

- Prepare/control the physical environment.
- Manage patient behaviour.
- Implement appropriate Policies & Procedures.

Types of Risk

The Types of Risk section encourages you to use a different perspective in approaching how to work with patients who have a history or recently diagnosed pattern of physical aggression/ violence. The traditional approach usually views issues of working with physically aggressive patients from a "one factor" perspective. That is, issues arise because there is insufficient and/or inappropriate staff training.

Safe Management promotes working with aggressive/violent patients from a "multi-factor" perspective. We train staff to manage physical aggression using a system-wide approach. A core concept is viewing physical aggression from a Risk Management perspective.

Patient to Staff	Staff to Patient	Between Staff
• Physical environment • Physical aggression • Medical status • Psychological needs	• Lack of-or inappropriate training • Improper implementation • Supervision/monitoring • Personal philosophy/values	• Communication • Conflicts among staff • Lack of behavioural management teamwork

System Organization Preparation

You should be prepared to deal with aggressive/violent patients who have predictable behavioural crises. It is important to consider the following legal and procedural requirements.

Intrusive Protocols

Intrusive Protocols are behaviour plans that include restrictive physical interventions, such as physically escorting someone against their will or using a physically restraining hold.

Ensure that Intrusive Intervention Procedures, such as physical restraints, are appropriately approved and reviewed.

LAST RESORT

Some plans may require staff to use physical supports. Consider such supports only under the following circumstances:

- It is determined that **less intrusive intervention** would be ineffective.
- There is a clear and **imminent risk** that the patient will physically injure him/herself or others.
- The techniques are carried out using the **least amount of force** necessary to restrict the patient's ability to move freely.
- While under restraint, the **patient's condition** is continually **monitored** and assessed.
- The **restraint is stopped** when there is no longer a clear and imminent risk that the patient will physically injure him/herself or others.
- The **restraint is stopped** when there is a risk that the restraint itself **will endanger the health or safety** of the patient.
- The procedure is **not used** for the purpose of **punishing** the patient.
- The procedures are appropriately approved and reviewed.

STRINGENT ACCOUNTABILITY

Intrusive intervention procedures, such as physical restraints, are regulated, and MUST BE:

a) DOCUMENTED IN WRITING.

b) APPROVED PRIOR TO USE.

c) MONITORED CAREFULLY, ON AN ONGOING BASIS, AFTER THEY HAVE BEEN APPROVED.

In all plans that use physical support procedures, document the following:

- That the patient's guardian(s) or substitute decision maker(s) have provided consent.
- A method of reviewing and evaluating the procedures with appropriate personnel (e.g., directors, supervisors, etc.) and other specialists in behavioural consulting (e.g., behavioural therapists, psychologists).
- Approvals from staff, supervisors and other individuals or committees deemed important to the integrity of the plan (e.g., a Behavioural Ethics Review Committee, the patient's physician). **The physician's opinion is absolutely necessary before an intrusive technique can be implemented.**
- Training and evaluation of staff in the physical techniques which have been approved to manage a behavioural crisis.
- Regular monitoring of staff's competence in implementing approved physical intervention procedures.

Environmental Preparation

Behavioural crisis can often be prevented by adequate preparation and planning. Environmental Preparation is one type of preparation that has been found to be most effective in preventing behavioural crises.

1. Room Furniture (Type & Location)	2. Size of Rooms	3. Hallway Access & Size
• Ensure no sharp or hard edges • Height of furniture • Locate against the walls so people are less likely to trip or fall over them, and have easy access to and from the room	• Large enough to allow safe patient-staff interaction during a behavioural incident involving more than two people	• Easily accessible and wide enough to permit staff and patients to move easily from one room to another if physical intervention is required • Provide sufficient room for staff to safely implement any interventions
4. Decorations and Objects	**5. Noise Levels**	**6. Amount of Space or Crowding**
• ***Selected*** **-** recognizing objects may be dangerous if broken and could be used as weapons • ***Not breakable*** **-** (e.g., pictures should be dry mounted rather than framed with glass) • ***Secured*** - in some way if they are large and heavy (e.g., wall units may need to be secured to the wall)	• Monitored and reduced, whenever possible (e.g., suggest classical or easy listening music) • If a patient has a preference for loud music, suggest using headphones • Stereos and Tvs should not be played at the same time and should be turned off during meals and instructional times. • Awareness of increased noise levels	• Ensure ample space for the number of people in the environment • In residential situations, use the entire house for living and workspace • Engage people in various activities in different areas

Environmental Preparation

7. Air Quality	8. "Calming" Area	9. Enhanced Staff
• Ensure good ventilation in all areas of the building, especially smoking areas and areas where noxious or highly scented objects are used	• Identify and reserve for times when an aggressive outburst occurs • Make easily accessible to most areas of the house or workplace (usually on the main floor in multi-level buildings) • Provide more than one area for a patient with frequent behavioural outbursts, especially in multi-level buildings	• ***Note: Various intervention techniques require additional staff to ensure their safe implementation*** • Use back-up call systems in situations where staff are working in different areas • Organize call systems with staff from nearby houses or buildings • Use "beepers" to activate back-up calls quickly
10. Staff's Room/Work Areas	**11. First Aid Kits**	**12. Lighting**
• Permit easy, on-going supervision of the patient by sight or sound • Provide easy, rapid access to a patient if an incident occurs • If ongoing patient monitoring is required, consider developing staff assignment systems for room supervision • If necessary, eliminate work areas that restrict constant patient supervision	• Make readily available and properly equipped for staff to deal with emergency situations, including the handling of blood • Be familiar with all kit locations and contents 	• Providing appropriate levels of lighting ensures easy monitoring of physiological changes • Psychologically, lighting has an effect on mood and mental well-being • Recognize that for some patients too much lighting can be problematic

EnviroScan™

In settings where there are patients who may display physical violence or aggression, an adequately prepared physical environment can help lower the probability of injury to patients and staff. The Safe Management EnviroScan™ process helps staff ensure the safety of their physical environment. Staff can use the Safe Management EnviroScan™ Guidelines to assess their home, special care environment and/or long term care facility.

Exits

- Doors that can be locked
- Areas that can be sealed off or isolated
- Number of exits
- Location of exits
- Hazards involving exits, e.g., stairs

Escape Routes

- For staff
- For patient
- Movement flow analysis completed
- Crisis evacuation routes determined
- Procedures for crisis available
- Practice frequency

Furniture

- Potential hazards identified
- Mobility blocks identified
- Furniture positioning shows awareness of, and planning for exits, escape/evacuation routes

Secured Environment

- Movement flow to room completed
- Location and swing of doors
- Space for intervention considered
- View for monitoring available
- Potential hazards removed

Potential Weapons

- Fire Extinguishers
- Tools
- Utensils
- Flower Vases
- Dishes
- Pictures
- IV Poles
- Canes/Walkers
- Hangers
- Finger/Toe Nails
- Needles
- Wheelchairs
- Phones
- Keys
- Pens
- Etc.

Be Safe....Stay Safe!

EnviroScan™ Checklist

	Scan	Caution	Consider	Check
Windows	Height from the floor Composition	Can a person be pushed through? Broken glass can cause injury	Placing furniture to block access Replacing glass with other material	
Mirrors/ Pictures	Method of attachment Composition	People could be pushed into a mirror Could be broken Broken glass can cause injury	Relocating Placing furniture to block access Replacing glass with safer material	
Doors/ Doorways	Door opens inward/ outwards from room How easily does the door open? How easy is it to unlock doors? How many exits from the room? How wide/tall are doors?	Door could slam into you Sole exit could be blocked by patient or door that opens the wrong way Central poles in double doorway could cause injury Staff could be locked in/out	Removing items blocking the doorways Making necessary repairs to facilitate the opening of doors Pocket doors Replacing lock with easily opened lock Ensuring staff can get in or out	
Hallways	Width of hallway Unobstructed access?	Limited room for movement Movements can be blocked easily by obstacles or patient	Removing potential obstacles Identifying potential exits along the hallway Presence of monitors	

EnviroScan™ Checklist

	Scan	Caution	Consider	Check
Phones	Working condition Location Accessibility	Be aware of the phone nearest you Could be used as weapon Phone location can increase staff vulnerability	Repairing all phones Testing phones before shift Positioning phones so calls can be made easily Posting emergency numbers near the phone	
Buzzers	Location Condition	Movement of high risk patients not monitored Non-working buzzers allow patients to leave the premises	Relocating buzzers to hard-to-reach locations for patients Testing buzzers regularly	
Environment Conditions	Noise Level Temperature Level	Could mask pre-aggressive clues Calls for assistance may not be heard Higher probability of aggression	Ensuring regular inspection Immediate repairs	
Exterior Environment	Sidewalks Grounds	Broken or damaged pathways Slippery conditions due to weather Yard ornaments could be used as weapons Yard tools could be weapons	Repairing pathways Ensuring weather safety procedures e.g., salt in winter Attaching yard ornaments firmly into ground Locking up yard tools	

EnviroScan™ Checklist

	Scan	Caution	Consider	Check
Ornaments	Composition Weight	Could be thrown Could be used as weapons	Removing Relocating to ensure difficult access	
Meal Trays/ Utensils	Location Cutting edge	Used as a weapon Serious injury could result against staff or patient	Installing locks on drawers Relocating to lockable drawers	
Cleaning Chemicals	Type of chemical Type of potential injury	Could be thrown at staff or others Could be used for self-harm	Storing securely when not in use Keeping only what is needed on hand	
Ceiling	Lighting Height of Ceiling Hanging plants/ fans/lights	Sufficient lighting? Low ceilings could cause injury from fixtures hung at low heights Low fixtures could be weapons after being pulled down	Replacing with brighter bulbs Ensuring bulbs are working appropriately Using recessed lighting Brighter paint for ceiling Raising low fixtures	
Carpets/Rugs	How was it installed? Condition/texture	Can you trip over exposed edges? Rugs could be pulled from under staff	No-slip flooring Replacing	

EnviroScan™ Checklist

	Scan	Caution	Consider	Check
Stairs	How wide is the staircase? Carpet/Bare	Could be pushed from behind Objects thrown from height Could be slippery	Keeping patient in front of you Installing higher railings Redirecting patient away from stairs	
Furniture/ Carts/Trolleys	Arrangement of furniture Size of item Shelves	Blocking movement flow to exits Location, can trip people Used as weapons Could shelves be tipped? Height of shelving - injury to head, trunk Blocking vision	Removing potential obstacles Rearranging to allow full view Attaching shelves firmly to wall Readjusting height of shelves Rounded edges or foam covers	

Stress Management

It is essential that good communication is established between staff, family members, caregivers and patients to help identify stressful times and ensure additional support is available as required.

Since it is our interpretation of events which influences our behaviour, it is critical that staff are aware of their own internal processes and use this knowledge when dealing with stressful situations. Staff can decrease and control their anxiety by following the 3 steps outlined below.

Step ONE	Step TWO	Step THREE
Staff need to become **AWARE** of what they tell themselves during a crisis situation. This means catching themselves and listening to what they are saying. Statements such as: "Oh my gosh, he's really going to hurt me!" or "Oh no, what am I going to do now?" or "Oh, I should never have taken this job!" Will tend to inflame the situation, increase anxiety, and likely result in an undesirable outcome.	Staff need to **CHANGE** what they tell themselves. The goal here is to create statements that are calming and reassuring. Positive self-statements such as: "Boy, this is a difficult situation, but I've handled this kind of thing before" can help maintain a sense of calm and control and will help to ensure that good decisions are made.  	Controlling and slowing down one's own breathing can boost positive self statements. When people are anxious or frightened, they tend to breathe quicker and shallower. This type of breathing tends to escalate anxiety. During a crisis, staff should monitor their breathing and ensure they are taking **long, slow, deep breaths.** This is most easily done by breathing out in a long, forced stream. The long breath out will trigger a deeper and longer breath in. This will begin to assist staff in calming themselves and will help them make decisions in a calm manner.

Summary

These self-management strategies are important because they reduce the chance that staff will act too quickly or impulsively. Deep breathing and positive self statements put staff in the right frame of mind in case they have to act in a more direct or intrusive manner.

Nutrition and Medication

When supporting patients, there could be a number of problems with their diet that need to be explored.

In general, people require a balanced diet consisting of a variety of healthy, fresh foods.

For these daily requirements, consult Eating Well with Canada's Food Guide, available from the Health Canada website. This guide indicates percentages and quantities for the daily intake of the various food groups in an easy-to-understand format.

There are also several other problems that could be related to food and dietary requirements. Poor nutrition can affect behaviour in negative ways, so dietary planning should be considered for each person.

When possible, light physical exercise is a good way to burn off excess fat and keep the metabolism in balance.

Where available, Nutritionists, Dieticians, Physicians, or Nutrition Services at Public Health Departments may be able to offer assistance to patients who require dietary suggestions or management.

Consider the following:

1. Does the patient have any developmental or medical problems that affect his/her diet, e.g., seizure activity/epilepsy, diabetes, and/or eating disorders?
2. Does he/she use **medications** that require dietary restrictions or counter the effect of other medications?
3. Does the patient have a tendency to **"cram" food, or choke easily**?
4. Does the patient suffer from **food allergies**?
5. Does the patient have access to snacks that are nutritious and healthy, rather than high fat, salty, sweet or caffeine-loaded foods?
6. Does the patient require education in proper eating and snacking habits, i.e., are they aware that some foods are healthier than others?
7. Has the patient's **appetite changed**, e.g., Never hungry, always hungry?

RELATIONSHIP MANAGEMENT

Section Two

Relationship Management is a critical element in the creation and management of safe environments. In many instances, outbursts occur because the patient is reacting to some aspect of the quality of his/her relationships with others. Your personal interaction with the patient can determine the outcome of such situations by the way you respond to unexpected crises.

This section describes 7 basic principles of Relationship Management with associated intervention techniques. These principles are effective strategies for managing relationships with others, including patients, colleagues, professionals and family members. The principles must be reinterpreted within the context of the patient's particular developmental level and processing characteristics. For some patients this may involve a more concrete design of the strategy.

At the end of this section participants should be able to:

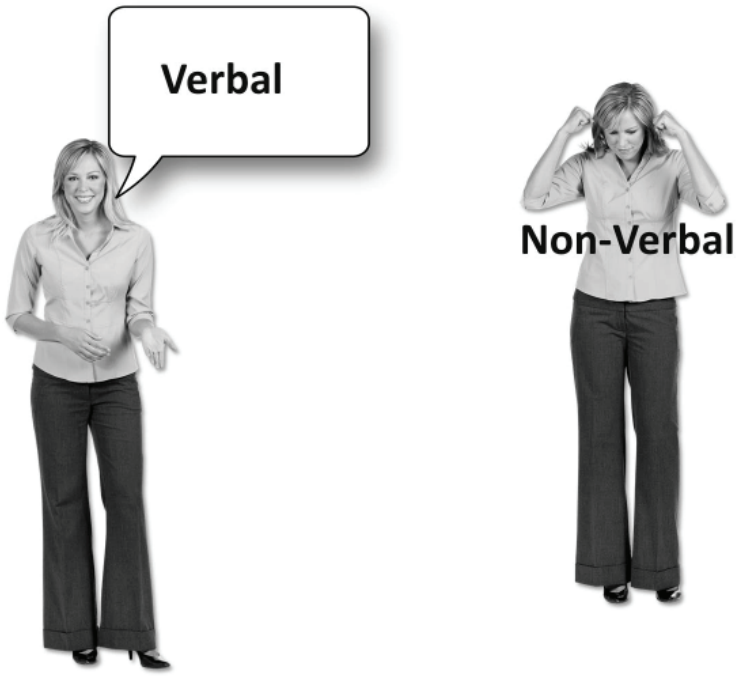
1. Identify the 7 Relationship Management Principles, implementation strategies and corrective techniques.
2. Demonstrate a working knowledge of how the Relationship Management principles relate to Verbal De-Escalation.

Communication

Good communication is the foundation for any relationship. We communicate using much more than words; many of our most effective and understood means of communicating are non-verbal. The way we stand, our facial expressions, our hand gestures, our tone of voice and our eye contact sometimes tell a much different story than the words we say, and they don't stop once we stop talking.

When communicating with a patient, remember to do the following:

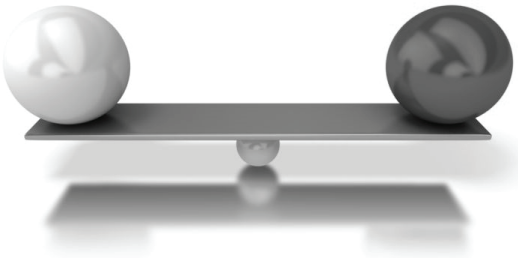
- Use the person's name.
- Always introduce yourself.
- Always speak to the person in an age appropriate manner.
- Speak clearly and slowly and explain what you are doing, e.g., helping them get ready for a bath.
- Use small words and simple sentences.
- Ask one question at a time.
- Make eye contact (when culturally acceptable).
- Try and use familiar words, pictures and/or charts to help them understand.
- Respect their physical space.
- Try not to rush them.

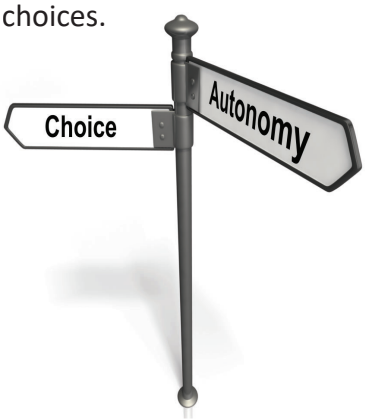


Relationship Management Checklist		
Principle	**Strategy**	**Technique**
Power & Equity	Assess if the patient has ***sufficient self-determination in daily routines.***	Provide greater choices in areas of insufficient self-determination.
Social Exchange & Reciprocity	Assess if relationship is imbalanced with ***insufficient positives and excessive negatives.***	Create relationship balance by giving more positives and reducing unnecessary negatives.
Empathy, Caring & Acceptance	***Communicate Empathy.*** ***Show Caring*** by responding to needs/wants. ***Show Acceptance*** by respecting rights.	Use 'active listening' skills. **Demonstrate** caring by putting the patient's needs before your own. Include the patient in decision making.
Genuineness & Openness	***Assess feelings towards the patient*** and the degree of sharing personal thoughts, feelings and experiences.	**Disclose** feelings, personal thoughts and information, while maintaining appropriate professional boundaries.
Reading & Responding to Emotions	***Assess Emotions*** using target indicators. ***Work through initial emotional expression***, then facilitate problem solving.	Work through emotions with active listening. **Problem solve** by defining the problem, brainstorming, weighing alternatives, and planning implementation.
Avoiding Coercion	***Identify Coercive*** behaviour. Avoid confrontation.	Don't 'give in' to coercion; **re-direct** by actively listening and problem solving.
Setting Limits and Interpersonal Boundaries	***Assess inconsistencies between staff*** and between various situations. Set limits, behavioural expectations and rules.	**Discuss** specific rules and limits with other staff; write them down to ensure consistency and review follow-through.

Power & Equity

Human beings have an innate desire to obtain as much power and control over their lives as possible, striving for freedom, autonomy and independence. This highly adaptive instinct ensures that we maximize our self-determination wherever we live.



Principle	Strategy	Technique
When freedom and control are repeatedly threatened, power inequities arise and conflicts ensue. While power inequities are an inevitable element of human interaction, continuous power inequities breed discontent, frustration and anger. Behavioural crises often result from the expression of anger and frustration with the power inequities in a patient's relationships. Lack of choices can lead to excessive behaviours or lack of behaviour.	**Identify** the crucial elements of the patient's environment. **Assess** whether the patient has sufficient control over and access to those elements. If the patient does not have enough control, **plan** opportunities for the patient to exert more control over their environment by providing choices. 	**Provide** more opportunities for him/her to make more choices regarding what he/she does and with whom. Be flexible about the times and locations where activities can take place. Identify what is hard or difficult for a patient and identify ways for them to move forward.

General Hospital Example:

Behavioural Problem:

Frank is a 48-year old man diagnosed with Huntington's disease. As part of the subcortical dementia he has gradually lost the ability to gauge his emotion. He was accompanied to Emergency by Police following an incident of physical aggression directed at his wife. Due to continuing aggressive behaviour, his wife no longer feels that she is able to care for him. Frank's wife reports that aggression is a typically encountered response in the home environment and is displayed when there is either a change in his daily established routine or when any of his requests are denied. During the first week of his admission to the hospital, Frank continued to express frustration with the admission, the hospital routine, and the repeated denial of his request to "go home". This resulted in frequent daily verbal outbursts and multiple incidents of non-compliance.

Staff Response:

The typical response in the home was to give in to his original demands (in order to minimize aggression), but his wife now believes that over time he has learned that being aggressive and belligerent allows him to get what he wants.

Assessment/Concept:

Based on the principles of **Power and Equity**, staff members assessed his situation and realized that Frank had too little input into his daily routine.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Power and Equity**, staff met with Frank in order to compromise on a daily schedule. Frank was presented with a list of scheduled assessment activities which included a list of preferred/usual activities. Frank worked with his Care Team in order to formulate a schedule that was as similar to his home schedule as possible. Even though Frank's schedule was not exactly what he was used to, he appeared less frustrated, his compliance with assessment activities increased and his outbursts decreased.

Mental Health Example:

Behavioural Problem:

Ted is a 28 year-old man diagnosed with Huntington's disease. As part of the subcortical dementia he has gradually lost the ability to gauge his emotion. He was accompanied to Emergency by Police following an incident of physical aggression directed at his parents. Due to continuing aggressive behaviour, the attending Psychiatrist placed Ted on a Form 3 and he was subsequently transferred to the hospital's psychiatric unit. During the first week of his admission to hospital, Ted continually expressed frustration with the admission, the hospital routine, and the repeated denial of his request to "go home". This resulted in frequent daily verbal outbursts and multiple incidents of non-compliance.

Staff Response:

The unit's routine around daily activities were scheduled by nursing staff without consultation with Ted. Ted's parents reported that aggression is a typically encountered response in the home environment and is displayed when there is either a change in his daily established routine or if any of his requests were denied. The typical parental response in the home was to give in to his original demands (to minimize aggression) but they now believe that over time he has learned that being aggressive and belligerent allows him to accomplish his goals.

Assessment/Concept

Based on the principle of **Power and Equity, staff** members assessed his situation and realized that Ted had too little power in determining his daily ward routines.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Power and Equity**, staff members decided that the present unit routine could be modified and made flexible with minimal disruption to overall unit practice. Staff met with Ted in order to compromise on a daily schedule. Ted was presented with a list of scheduled assessment activities which included a list of preferred/usual activities. Ted worked with his Primary Nurse in order to formulate a schedule that was as similar to his home schedule as possible. Even though Ted's schedule was not exactly what he was use to, he appeared less frustrated, his compliance to assessment activities increased and his outbursts began to decrease.

Social Exchange & Reciprocity

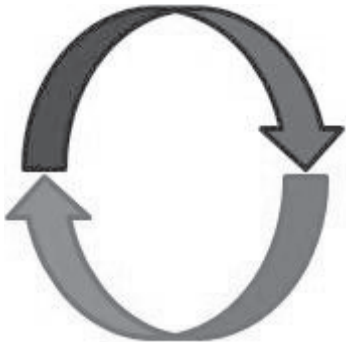
Patient's are very sensitive to the number of positive and negative experiences they have with other people.

Positive Reciprocity	Negative Reciprocity
When we receive many positive experiences from someone, we are more likely to respond or reciprocate with another positive experience. **Example:** If staff interact with a patient in a positive manner, the patient is motivated to return the positive experience and may be more cooperative when doing an "unpreferred" or a less desirable task.	***When we receive a negative experience from someone, we are more likely to reciprocate with a negative experience.*** **Example:** If a staff member is forceful when assisting a patient with dressing on one occasion, the patient may be more motivated to return the negative experience by refusing to do a task when asked by the same staff.

Positive and negative reciprocity are both examples of the methods we use to maintain a balance between positive or negative experiences that we give to and receive from others - similar to a social bank account.

This balancing process often operates at an unconscious level. We usually do not make conscious calculations of the positives and negatives in each relationship; however, research indicates that equality in positive and negative exchanges is well maintained in normal relationships.

Social Exchange & Reciprocity

Principle	Strategy	Technique
Human beings are motivated to maintain an equal level of positive and negative exchanges with others - we give what we get. A patient in an unbalanced negative relationship is likely to display negative emotions such as frustration, uncooperativeness and anger. You can also expect behavioural crises to develop. 	When dealing with a patient who has had a behavioural crisis, do the following: • **Assess** if the number of positive exchanges with the patient have been adequate. • **Review** recent negative exchanges that may have motivated the patient to reciprocate negatively. If you decide the behavioural crisis occurred as a form of negative reciprocity, do the following: • **Plan more positive experiences for the patient.** • **Reduce the patient's negative experiences.**	Review your relationship balance with the patient and determine the following: • Is the patient receiving enough **positive** experiences. • Is the patient receiving too many **negative** experiences. If you decide the patient is receiving too many negative experiences, plan more positive experiences or reduce unnecessary negative ones. 

Mental Health Example:

Behavioural Problem:

Bill, a 24 year old patient with schizophrenia, became angry with his nurse, Frank, and assaulted him during a shift. Staff met after the incident to review Bill's relationships with the various staff that supported him, including his relationship with his nurse.

Staff Response:

Staff's response to the aggression on the unit was to keep interactions to a minimum because of fear of further conflict and aggression.

Assessment/Concept:

Based on the principles of **Social Exchange and Reciprocity**, staff members realized there were few opportunities for Frank to interact in a reinforcing manner with Bill, such as taking him for a walk off or around the unit or asking him about his day.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Social Exchange and Reciprocity**, there seemed to be an imbalance in Bill's relationship with Frank. As a result, Frank made sure that he took a few minutes out of his shift to talk to Bill about his day. Frank also made an effort to accompany Frank during a supervised walk off the unit.

General Hospital Example:

Behavioural Problem:

Todd, a 34-year old male with schizophrenia, became angry with Steve, a staff member with the Assertive Community Treatment Team (ACTT), and assaulted him during his daily home visit. Staff met after the incident to review Todd's relationships with the various staff that supported him, including his relationship with Steve.

Staff Response:

Upon review, staff members realized that Steve could not establish a positive rapport with Todd due to limited time restraints during his in-home visits.

Assessment/Concept:

Based on the principles of **Social Exchange and Reciprocity**, possible reasons for the imbalance in Steve and Todd's relationship were identified:

- Steve was part-time and thus worked fewer hours than his coworkers.
- Steve only administered Todd's medication and provided him with his daily cigarettes.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Social Exchange and Reciprocity**, there appeared to be an imbalance in Todd's relationship with Steve. As a result, Steve spent an additional 10 minutes with Todd at the end of each visit in order to interact with him in a reinforcing manner and strengthen their therapeutic relationship.

Empathy, Caring & Acceptance

Showing **Empathy, Caring and Acceptance** is important in preventing and managing crisis episodes.

Empathy	Caring	Acceptance
Communicating to someone else that you appreciate his/her situation and inner emotional experiences.	Demonstrated by accurately identifying the patient's needs, feelings and wants and responding promptly to them.	Occurs when a patient is respected and welcomed, even though current behaviour may be unacceptable to those around them.

Principle

Communicating Empathy, Caring and Acceptance is important for maintaining harmonious interpersonal relationships.

The absence of emotional support can create disharmony, discontent and interpersonal conflict (i.e. behavioural crisis).

Strategy

When working with a patient who is prone to episodes of behavioural crises, do the following:

- ***Assess*** whether there are sufficient signs of Empathy, Caring and Acceptance in the patient's relationships.

If these elements are lacking, do the following:

- ***Review*** plans to increase these aspects of the patient's care.
- ***Provide training*** sessions to help staff effectively communicate Empathy, Caring and Acceptance.

Empathy, Caring & Acceptance

Actively listen when the patient attempts to communicate with you by doing the following:

1. Pay Attention
Pay attention by looking at the patient and avoiding distractions. Listen intently to their words and be aware of their non-verbal messages.

2. Acknowledge
Acknowledge the patient's feelings and repeat in your own words what you heard him/her say.

3. Encourage
Encourage the patient to communicate more.

Incorporate the following verbal and nonverbal cues:

- Make good eye contact.
- Nod with understanding or agreement.
- State the patient's feelings by labelling them.
- Ask the patient to confirm your understanding.
- Ask the patient to tell you more.
- Wait until the patient has finished talking before answering.

It is important, when using these strategies, that staff do not try to control the patient by providing solutions to them or redirecting the conversation. Active listening shows Empathy, Caring and Acceptance as the patient is encouraged to communicate more. Control strategies reduce the chances that the patient will feel heard, validated and will want to contribute.

Caring

Show you are responsive to a patient's needs and wants by **asking the following:**

- What do you need/want?
- Do I correctly understand your need/want?
- Can I provide for that need/want?
- What is the best way to address your need/want?

Note: ***A caring response includes giving your time and attention*** at the moment the patient need/want is experienced. Delaying or waiting until it is convenient for you to respond does not demonstrate caring.

Acceptance

- ***Openly and honestly state*** what you like about the patient.
- ***Respect*** his/her wishes, even though they may represent an inconvenience.
- ***Include*** the patient in decision making, whenever possible.
- When appropriate, ***clearly communicate*** that a specific behaviour is unacceptable, but that the patient is still accepted.

Mental Health Example:

Behavioural Problem:

Janice was recently admitted to the hospital due to increasing episodes of verbally aggressive behaviour directed at her lodging home staff. Janice's behaviours continued during the admission, with repeated verbally aggressive statements directed at staff and co-patients. Janice's Primary Team met to discuss her behaviours and review her daily behaviour observation data sheets.

Staff Response:

Staff members were attempting to decrease her verbal aggression by immediately approaching her and directing her to her room. (i.e. "Your behaviour is unacceptable you need to go to your room until you are calm").

Assessment/Concept:

Staff met to review their approach. Using the principles of **Empathy, Caring & Acceptance,** they concluded that their behaviour of redirecting her and telling her that her behaviour was unacceptable was not communicating Empathy, Caring & Acceptance. They concluded that giving her some time to communicate her feelings might be a better approach.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Empathy, Caring and Acceptance,** staff immediately reviewed their active listening skills that would show Janice greater empathy. They developed a script outlining what staff would do and say when Janice began to engage in verbal aggression. It included such statements as "Janice, I can see you are upset, tell me more about how you are feeling?"

General Hospital Example:

Behavioural Problem:

Mandy, a 16 year old girl was brought into the Emergency Room as a result of a Tylenol overdose. She was placed on a Form 1 and brought to the Pediatric unit to be medically stabilized with plans to admit her to the Child and Adolescent unit. She was upset about her admission and became aggressive towards her Care Team when the rules of the unit were explained to her.

Staff Response:

Staff's immediate response was to call security. She escalated further in response to this, and eventually was chemically restrained and placed in locked seclusion.

Assessment/Concept:

Mandy's Care Team met to discuss her behaviours and reviewed her daily documentation notes. Using the principle of **Empathy, Caring & Acceptance**, they concluded that their immediate use of security probably did not communicate Empathy and Caring, but may have frightened her causing her to further escalate.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Empathy, Caring & Acceptance**, they developed a script in the nursing plan for providing short-term active listening to let her express her fears, anger, and frustration before using emergency back-up security.

Genuineness & Openness

Openness, Honesty and Self-disclosure are important elements in maintaining a positive relationship with a patient, fostering closeness, friendly behaviour and camaraderie. Conflicts may develop when these elements are absent.

Principle	Strategy	Technique
Openness, Honesty and Self-disclosure increase the closeness of your relationships. 	Share appropriate feelings, thoughts and information to: emotional distance. **Assess the genuineness of your interactions with your patient.** Is your non-verbal communication (body language, voice, tone, volume, facial expressions) congruent with your verbal message? **Important:** When staff are learning how and when to share appropriate feelings, thoughts and information with a patient, ensure that experienced care providers supervise all interactions.	If you have a conflict-ridden patient relationship with frequent episodes of anger and uncooperativeness, review the emotional closeness of your relationship. **Consider the following:** • How you feel about the patient. • How the patient feels about you. • Whether the patient shares personal feelings, thoughts, and experiences and whether you reciprocate. **Note:** The answers may indicate too much or too little closeness. Take the appropriate action.

Staff should be aware of professional boundaries when considering self-disclosure.

Genuineness & Openness

Openness, Honesty and Self-disclosure are important elements in maintaining a positive relationship with a patient, fostering closeness, friendly behaviour and camaraderie. Conflicts may develop when these elements are absent.

Principle	Strategy	Technique
Openness, Honesty and Self-disclosure increase the closeness of your relationships 	Share appropriate feelings, thoughts and information to: • Improve the emotional bond you share with the patient. • Promote friendly behaviour and mutual caring. • Decrease conflict and emotional distance. **Assess the genuineness of your interactions with your patients.** Is your non-verbal communication (body language, voice, tone, volume, facial expressions) congruent with your verbal message? **Important:** When staff are learning how and when to share appropriate feelings, thoughts and information with a patient, ensure that experienced care providers supervise all interactions.	If you have a conflict-ridden patient relationship with frequent episodes of anger and uncooperativeness, review the emotional closeness of your relationship. **Consider the following:** • How you feel about the patient. • How the patient feels about you. • Whether the patient shares personal feelings, thoughts, and experiences and whether you reciprocate. **Note:** The answers may indicate too much or too little closeness. Take the appropriate action.

Staff should be aware of professional boundaries when considering self-disclosure.

Mental Health and General Hospital Example:

Behavioural Problem:

Howard rarely interacted with unit nursing staff during the shift. After frequent episodes of uncooperativeness and anger, staff members met to review Howard's behaviour. The emotional closeness of staff's relationship with Howard was considered.

Staff Response:

It became apparent that nursing staff did not initiate conversations with Howard, and when they did the interactions were always about routine activities.

Assessment/Concept:

Based on the principles of **Genuineness and Openness** , it was determined that interactions with Howard were usually initiated in order to issue medications or to provide prompts to complete scheduled activities. Staff acknowledged that they were uncertain if Howard liked them. Staff admitted that they shared few positive experiences with him. They acknowledge that this affected their relationship with Howard.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Genuineness and Openness**, staff immediately scheduled 1:1 time intermittently throughout each day when unit duties would allow. These times allowed Howard and staff to get to know each other better. It took time, but eventually staff reported that Howard was cooperating more, appeared happier and initiated many more interactions with staff during all shifts.

Reading & Responding To Emotions

Misconception	Functions of Emotions
One of the biggest misconceptions about human emotions is that they are irrational. Very intense emotions can blind us to certain facts about a situation and prevent us from understanding other points of view. Emotions can also play a positive, helpful role in our daily experiences.	Emotions are **highly adaptive,** physical events that induce quick, **adaptive action.** Each emotion evolved biologically because it helped human beings adapt to certain situations over time. All emotions are important in the management of human relationships.

The following table examines some basic emotions, their common indicators and their function.

	Fear/Anxiety	Anger	Sadness	Joy
Indicators	• Tense body • Clenched jaw/fists • Scowling • Tight facial expression • Averted gaze • Tears • Greater physical distance • Shaky limbs • Nausea • Frequent urination	• Tense body • Clenched jaw/ fists • Intense eye contact • Showing teeth when talking • Loud verbal behaviour • Less physical distance • Waving arms • Shakiness	• Tearfulness • Crying • Slumped shoulders/body • Soft voice • Verbal expression of disappointment, resignation, hopelessness or regret	• Smiling • Energized body • Laughing • Quick movements • Verbal expression of euphoria, happiness
Function	• Alerts the body that something dangerous or harmful is going to happen • Mobilizes reaction to flee, avoid or withdraw from the situation	• Alerts the body to a threat or possible harm • Motivates reaction to defend against, or attack, the source of the threat (e.g., defending rights)	• Alerts the body that something of value has been lost or cannot be attained • Motivates reaction of withdrawal	• Alerts the body that something self-beneficial has occurred • Motivates repetition of instrumental actions for further self-benefit

Reading & Responding to Emotions

Basic human emotions are highly evolved biological mechanisms that promote adaptive action. Each emotion has an adaptive function and motivates an adaptive action, such as fear -> withdrawal, anger -> self-defense, sadness -> accepting the unattainable, joy -> instrumental action. Several principles, strategies and techniques are helpful in using emotions to effectively solve problems.

Strategy for Effective Problem Solving

Phase One

Working Through Initial Emotions

Ensure that the patient's emotions are:

- Being heard and understood.
- Not being questioned, challenged or judged.
- Respected and that his/her feelings are validated.

Phase Two

Facilitating Problem Solving

- Guide and motivate to resolve the emotion.
- Gently direct the patient through problem solving.
- Help the patient identify the problem.
- Brainstorm with the patient about options that might solve the problem.
- Weigh the suitability of the options with the patient.
- Develop a plan with the patient to implement the solution.

Mental Health Example:

Behavioural Problem:

Stephen was returned to the unit accompanied by his recreational therapist. He was accompanied to the nursing station to meet his assigned nurse Barb. Stephen immediately started screaming at Barb stating "I'll never go to programming again". Stephen then started punching his chest and pacing in front of the office.

Staff Response:

Nurse Barb responded by warning him that such behaviour would result in a PRN, he shouted back that he didn't care. Staff called for back-up. With multiple staff present, he threatened to harm himself. Staff physically intervened and transported him to locked seclusion, at which time he was given an injectable PRN while being restrained.

Assessment/Concept:

Staff debriefed after the incident, and using the principle of **Reading and Responding to Emotions**, they concluded that their immediate response of threatening to give a PRN and calling security probably did not communicate Empathy and Caring, but may have triggered further negative emotion.

Solution - Strategy/Technique:

Staff debriefed after the incident, and based on the strategies and techniques of **Reading and Responding to Emotions**, they completed SMG's Behavioural Profile, and developed a verbal de-escalation script involving working through and problem solving.

Mental Health Example Continued:

Implementation:

Phase One – Active listening. As staff predicted, a similar incident occurred the next day, and the staff implemented the strategy-techniques outlined in the principle of **Reading and Responding to Emotions**.

Stephen was returned to the unit accompanied by his recreational therapist. He was accompanied to the nursing station to meet his assigned nurse Barb. Stephen immediately started screaming at Barb stating, "I'll never go to programming again". Stephen then started punching his chest and pacing in front of the office. Nurse Barb knew these behaviours were recorded as "Subtle Changes" in his Behavioural Profile so she immediately implemented Phase One – Active listening skills for "working through emotions" and said "I can see you are really upset. Do you want to talk to me about it?" Barb knew not to verbalize and/or make requests at this time so she walked back and forth with Stephen in the hallway while he continued to be angry. Barb acknowledged and summarized Stephen's feeling by saying, "I can see something at your recreation program has made you so angry that you don't want to go back. Is that right?" Stephen immediately shouted back "Yeah, it's my stupid therapist, he made me sit first during the floor hockey game, and I sat first last week! He must hate me. He likes the other guys or he's trying to make me so mad so I don't come anymore." Barb continued to show signs of active listening and empathy for Stephen. In order to communicate this, Barb said "So your therapist sat you first again this week and that made you mad".

Over the next 15 minutes, Stephen continued to verbalize his anger at his recreation therapist, his need for programming and his hospital stay. As he spoke, Barb watched Stephen's emotions move from anger to disappointment, to sadness and he began to pace less and his voice gradually decreased to normal conversation tone.

Phase Two – Problem Solving. Barb recognized these common signs of emotional expression and judged that Phase One was ending. She decided that it was appropriate to begin the Phase Two technique. Barb asked Stephen if he thought there was anything he could do about sitting first at the floor hockey game. Stephen was now ready to explore some options but said, "He's the boss, I've tried everything, he doesn't listen". Barb offered her assistance by replying "I guess sometimes it seems hopeless, but would you like me to help you find something you can do?" Stephen accepted her offer and Barb assisted him in working through several options.

Stephen eventually decided he liked an option that involved arranging for a meeting where he and Barb could talk to his recreation therapist. Stephen learned that intense negative emotions are not necessarily bad and that they can lead to solutions when they are expressed and worked through. Barb and the unit staff averted numerous future incidents by investigating any additional problems at other programs, as well as recreation even though the initial presentation of the problem became apparent through a behavioural crisis.

General Hospital Example:

Behavioural Problem:

Stephanie, a 21-year old woman with Borderline Personality Disorder, began picking at stitches on her arm and became increasingly anxious during the latter part of the afternoon when she saw her nurse attending to other patient's. After shift change, Stephanie began to pace back and forth in front of the nursing station and bang her head on the wall repeatedly. She also began to protest and yell that she did not want Janine, the day shift nurse, to be her nurse again.

Staff Response:

Staff responded by warning Stephanie that if she continued to harm herself, she would have to take her PRN. Stephanie shouted "I don't care, I want to die!" Staff called back-up and she was transported to her bed, placed in bed restraints, and given her PRN.

Assessment/Concept:

Staff debriefed after the incident, and using the principle of **Reading and Responding to Emotions**, they concluded that their immediate response of threatening to give a PRN and calling security probably did not communicate Empathy and Caring, but may have triggered further negative emotion.

Solution - Strategy/Technique:

Staff debriefed after the incident, and using the strategies and techniques of **Reading and Responding to Emotions**, they completed SMG's Behavioural Profile, and developed a verbal de-escalation script involving working through emotions and problem solving.

General Hospital Example Continued:

Implementation:

Phase One – Active listening. As staff predicted, a similar incident occurred the next day, and the staff implemented the strategy-techniques outlined in the principle of **Reading and Responding to Emotions**.

After shift change, Stephanie began to pace back and forth in front of the nursing station and bang her head on the wall repeatedly. She began to protest and yell that she did not want Janine, the day shift nurse, to be her nurse again. Patricia, the afternoon shift nurse, immediately implemented Phase One - Active listening skills for "working through emotions". "Do you want to talk to me about it?" Patricia knew not to verbalize and/or make requests at this time so she walked back and forth with Stephanie in the hallway while she continued to be angry. Patricia acknowledged and summarized Stephanie's feelings by saying, "I can see that something made you angry when you were with Janine and you don't want her to be your nurse anymore. Is that right?" Stephanie immediately shouted back "Yeah, I'm feeling anxious and she has been ignoring me all day. She hates me!" Patricia continued to show signs of active listening and empathy for Stephanie. In order to communicate this, Patricia said "So your nurse didn't have the time you needed today and that made you angry."

Over the next 15 minutes, Stephanie continued to verbalize her anger towards her nurse and her need for attention. As she spoke, Patricia watched Stephanie's emotions move from anger to disappointment, to sadness and she began to pace less and her voice gradually decreased to a normal conversational tone.

Phase Two – Problem Solving. Patricia recognized these common signs of emotional expression and judged that Phase One was ending. She decided that it was appropriate to begin the Phase Two technique. Patricia asked Stephanie if she thought there was anything she could do about soothing her own anxieties. Stephanie was now ready to explore some options, but said "I've tried everything, nothing works." Patricia offered her assistance by replying "I guess sometimes it seems hopeless, but would you like me to help you find something you can do?" Stephanie accepted her offer and Patricia assisted her in working through several options.

Stephanie eventually decided she liked an option that involved writing in a journal. Stephanie learned that intense negative emotions are not necessarily bad and they can lead to solutions when they are expressed and worked through. Patricia and the Care Team averted numerous future incidents by directing Stephanie back to her journal.

Techniques for Reading & Responding to Emotions

Phase One

Allow the patient to express emotions naturally and adaptively. Instead of interrupting the patient during this process, which can make the patient angry and intensify the problem, use the **active listening skills** described in the "Empathy, Caring and Acceptance" portion of this section.

Active Listening involves these skills:

- ***Looking*** at the patient and listening carefully to the words they use.
- ***Paraphrasing*** what has been said, with special emphasis on emotions, (e.g., "You felt put-down and embarrassed").
- ***Encouraging complete communication by*** prompting the patient to communicate more. Ask questions (e.g. "Can you tell me more about why this situation was so embarrassing for you?").

Phase Two

Engage the patient in these ***four steps of problem solving***:

1. Identifying the problem
2. Brainstorming solutions
3. Weighing options
4. Implementing the plan

Phase Two techniques should ***only be implemented after the initial intense expression of emotion*** in Phase One is clearly over. Any effort to prompt and support rational problem solving too early will only interrupt the patient's emotional expression, resulting in anger.

Avoiding Coercion

Coercion occurs when we threaten to punish or withdraw privileges from someone, unless that person cooperates and does what we want them to do.

Coercion

You are being coerced when the following occurs:

- A patient begins unacceptable behaviours in response to something you have done that the patient does not like.
- The behaviour only terminates when you provide whatever it is the patient wants.

When the above behaviour happens, negative reinforcement occurs (where avoidance and escape behaviour are reinforced).

Coercive Interactions

Coercive interactive cycles are personal interactions in which coercion is involved and both patient and staff receive reinforcement for their behaviour.

Example: A staff threatens to punish an patient or withdraw privileges when the patient behaves unacceptably. When the patient stops their behaviour, it reinforces the staff's threatening behaviour. As a result, threatening the patient may become a habit.

Note: The patient may also receive reinforcement of coercive aggressive behaviour in those situations where the caregiver "gives in" to the "demands" of the patient in order to stop the aggressing. This too can become a habit. These interlocking behaviours are called interactive cycles.

Coercive Interactive Cycles

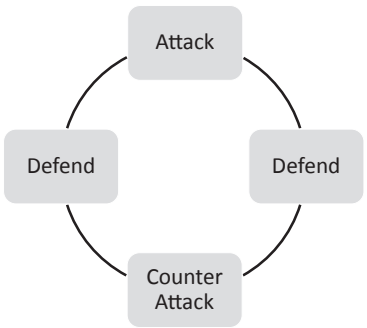
During a behavioural crisis, it is not uncommon for staff to try and escalate their demands through threats of punishment or the withdrawal of privileges. In the past, this approach has been negatively reinforced by the cessation of inappropriate behaviours. However, because many patients often respond to threats with more intensely aggressive behaviour (this response has also been strongly reinforced in the past), punishment/withdrawal strategies can quickly trigger **a coercive interactive cycle, leading to greater risk for both people**.

One of the best ways to avoid becoming trapped in coercive interactive cycles is to use the strategies and techniques described in the **"Reading & Responding to Emotions"** section.

Know and implement the policies and codes of conduct fairly and consistently.

Avoiding Coercion

The following are guidelines for dealing with coercion-based situations:

Principle	Strategy	Technique
People often unknowingly respond to behavioural crises with escalating behaviour. This type of response can: • Become part of a coercive interactive cycle. • Raise the risk of harm to both the patient and the staff.  	Be aware that a patient may be engaging in coercive interactive behaviour,when either or both of the following occur: • His/her behaviour escalates when confronted with something undesirable. • He/she only exhibits a willingness to stop if the situation is changed in his/her favour. In order to break the cycle, actively avoid confrontation.	Below are the most useful techniques for avoiding confrontation: • Ignore the behaviour • Actively listen • Problem solve **Note:** These techniques can be used in combination to successfully redirect escalating behaviour toward a more successful outcome.

Mental Health Example:

Behavioural Problem:

Ingrid's daily treatment schedule required 4 hours of off-unit programming. Lately, shift notes indicated that Ingrid has been repeatedly returned to the unit by program staff. Upon her return, she would immediately go to the TV room and rest in front of the television. Initially, when staff approached Ingrid she stated she returned to the unit because she was ill. Staff did not inquire further. As the week progressed, Ingrid returned to the unit more frequently. Inquiries from staff resulted in Ingrid refusing to talk to staff. Staff contacted the program where they were told Ingrid was being returned to the unit because she was refusing to participate.

Staff Response:

Program staff reported that previously, repeated requests to engage would result in participation but overtime, these requests were unsuccessful and Ingrid began to be verbally aggressive. Staff soon stopped prompting her to engage. Program staff now report that Ingrid is returned to the unit after 10 minutes if she does not engage in programming. They stated that prompting to engage has been discontinued in order to avoid Ingrid from being verbally aggressive.

Assessment/Concept:

Based on the principles of **Avoiding Coercion,** Ingrid's Primary Team discussed this situation with her off-unit programming staff. They acknowledged that on some days Ingrid did not want to participate in programming, and her behaviour allowed her not to participate. They also agreed that allowing Ingrid to watch television in place of the scheduled programming added to the problem. Ingrid learned that staff would withdraw their requests to engage in programming and return her to the unit if she behaved aggressively and program staff learned that withdrawing their request to engage would stop Ingrid from becoming aggressive. A mutually reinforcing pattern of coercive interaction was being developed.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Avoiding Coercion**, staff decided that allowing Ingrid to choose if she wished to participate in programming prior to attending the program will minimize this coercive behaviour. Unit staff would schedule an alternative program on the ward to be completed on days that she wished not to engage in off-unit programming. This would not allow her to return and watch television.

General Hospital Example:

Behavioural Problem:

Mr. Smith comes to the ED at 09:35 with a 3-day history of abdominal pain and vomiting. The ED is very busy and the wait to be seen by a physician is 4 hours. The nurse, Ms. Johnson does a triage assessment and determines that his acuity level is at CTAS Level 3. She asks him to register, advising him that there is a 3-4 hour wait and asks him to have a seat in the waiting room. At 10:30 Mrs. Smith comes to the triage desk stating that her husband has been waiting long enough, she has to get to work and demands that her husband see a doctor by saying "I demand that my husband be seen NOW!" Ms. Johnson feels angered by this, and states that "You are not the only patient in the hospital needing attention, and you will have to wait!" Mrs. Smith yells "Fine then! I will be calling our lawyer!" Ms. Johnson now feeling even more angered and stressed, responds "If you don't sit down, I will have to call security to remove you from the ED!" Mrs. Smith stomped back to her seat and began complaining loudly to other patients in the ED.

Staff Response:

Other ED nurses had observed Ms. Johnson's behaviour during this and other incidents and felt uncomfortable. Also, they noted that other ED nurses under those same circumstances might have given in to the threatening patient's family member and they worried this created inconsistencies that might cause problems.

Assessment/Concept:

Using the principle of **Avoiding Coercion,** staff met and they raised the issue of how to handle angry ED patient's and their families. They noted that this aggressive approach increases the risks that patients will leave the ER without seeing a physician. There is also the risk that the nurse will fail to appropriately reassess patients in the waiting room with the potential of missing a deterioration in their conditions. They also noted that in such situations, Ms. Johnson learned that raising her voice and threatening patients with expulsion from the hospital would stop aggressive patients from escalating. Also, they felt that Mrs. Smith learned that shouting and threatening would not work to gain immediate medical attention.

General Hospital Example Continued:

Solution - Strategy/Technique:

Based on the strategies and techniques for **Avoiding Coercion,** a number of suggestions were offered including: ignore the aggressive behaviour, actively listen to the angry patient or family member and look for solutions. In the situation with the Smiths, it was noted that a reassessment of Mr. Smith needed to occur as well. Did Mrs. Smith believe that he was getting worse? Is there a child she needs to tend to at home? Does she have a job she needs to get to? Can she attend to her own needs and leave Mr. Smith in the ED?

Setting Limits & Interpersonal Boundaries

Some patients will engage in escalating aggressive behaviour in order to determine the limits of a staff's tolerance.

Principle

Teach patients the boundaries of acceptable behaviour and help them effectively access needed or wanted objects and activities.

At all times, provide a consistent response:

1. In different situations.
2. From all staff on the same issue.

Strategy

When managing behavioural crises, it is important to ensure the following:

- ***Set consistent limits regarding what is considered acceptable social behaviour.***
- Set the degree of acceptable freedom around certain objects and activities.
- Establish greater consistency in how all staff implement the established limits.

Techniques

- **Review your own unstated rules about behaviour** and be aware that you are using some type of rule.
- **Write down the rules you think you are using** and communicate them to the patient.
- **Frequently and regularly review and communicate with other staff** about their rules surrounding different daily situations.
- **Negotiate and compromise with other staff on less important rules** to ensure all staff are following the same rules.
- **Record staff rules** and have everyone read and sign them to ensure awareness and consensus.
- Do not accept that a staff's description of the rules is actually **how the rules are being applied. Instead, arrange for staff to observe each other** in selected situations, so staff can see if the stated rules are being practiced.

Mental Health and General Hospital Example:

Behavioural Problem:

Colin assaulted his assigned nurse during "medication" time. He became agitated and very upset after staff repeated their requests for him to take his medication.

Staff Response:

The staff member informed him that he could not go to breakfast until he had taken his medication.

Assessment/Concept:

Based on the principles of **Setting Limits and Interpersonal Boundaries**, staff discussed the incident and it became apparent that other nursing staff were allowing Colin to eat his breakfast prior to taking his medication. Staff acknowledged that Colin's non-compliance and eventual aggressive response likely occurred because, over time, he had been allowed to take his medication after breakfast if he wished.

Solution - Strategy/Technique:

Based on the strategies and techniques for **Setting Limits and Interpersonal Boundaries**, a new consistent medication dispensing script was immediately developed. Nursing staff would now provide Colin with one prompt outlining his option of taking his medications before breakfast or after he completed breakfast. Data indicated that Colin almost always requested to take his medications after breakfast, and his Primary Team rearranged his medication time to reflect this preference.

NOTES

BEHAVIOUR MANAGEMENT

Section Three

There are many important questions to answer when planning preventively. This section provides a worksheet, with a systematic set of questions and issues to address, to help with planning, e.g., knowing how the patient learns best, how the patient uniquely communicates his/her wants and needs and how the patient expresses his/her aggressive behaviour in response to specific triggers. Knowing early warning signs of frustration and agitation and developing specific intervention strategies are critical elements.

At the end of this section participants should be able to:

1. Identify and understand the importance of the essential elements or pre-requisites of a nurturing supportive environment/milieu.

2. Understand behaviour from the Antecedent, Behaviour and Consequence, the (ABC) perspective.

3. Demonstrate a working knowledge of the various Functions of Behaviour.

4. Develop a Behaviour Profile for a patient.

5. Develop a Behaviour Plan based on a patient's functions of behaviour and behaviour profile.

6. Identify and apply anger management strategies to help patient's cope with anger and frustration.

Environmental Planning

Patient welfare can be improved with the help of medical and psychiatric assessments and treatment. You should also develop a written plan to help prevent predictable and recurring incidents of violence/aggression. Consider the three pre-requisites for programming discussed in the MCSS "Standards for Behavioural Programming for Facilities for the Developmentally Handicapped" (1986), Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008, and Ontario Regulation 299/10 - Quality Assurance Measures.

Environmental Prerequisites for Programming

Functional Activity	Attention	Development of Alternative Behaviour
Remember: ***Aggressive behaviours are reduced when boredom and under-stimulation are minimized.*** ***Therefore, ensure patient's*** have meaningful functional activities and leisure activities that are scheduled and planned.	***Remember:*** ***Friendly, reinforcing communication helps prevent loneliness, social isolation, withdrawal and attention seeking behaviour.*** ***Therefore, ensure patient's*** receive adequate levels of positive reinforcement through social interaction with other patients and staff.	***Remember:*** ***Demonstrations of appropriate behaviour, such as positive interactions with others and complying with staff requests, need to be reinforced.*** ***Therefore, ensure patient's*** are taught how to access meaningful, social and material reinforcement from their environment (e.g., how to turn on the television, listen to music, talk to other patients/ staff, or travel to the park). If such skills are difficult to learn or would take too long, ensure the patient receives adequate reinforcement for engaging in activities that involve positive interactions with others.

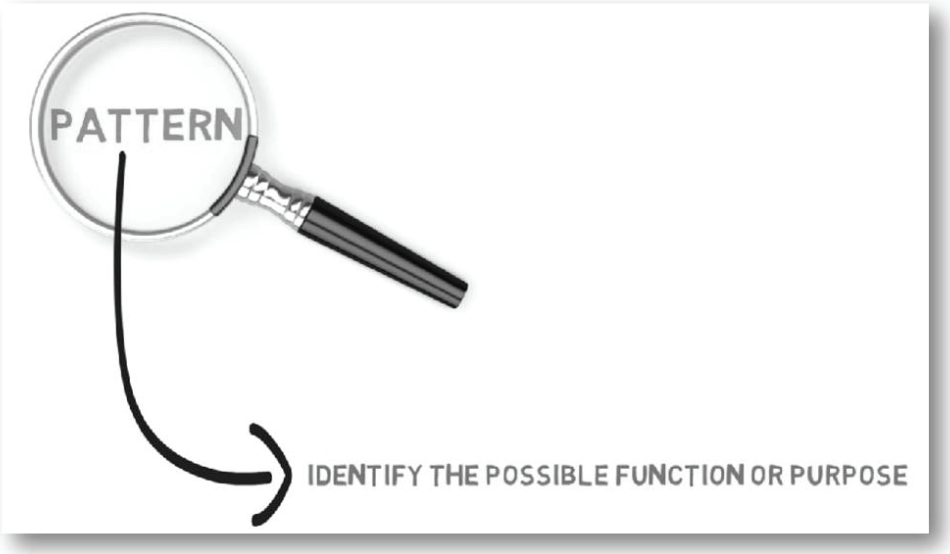
Functions of Behaviour

By examining the specific functions or underlying meaning of a patient's behaviour, ***you will learn how to avoid negative behaviour and encourage more appropriate social behaviour.***

Most recurring behavioural outbursts fit a pattern.

Observe and **Assess** all inappropriate and aggressive behaviour in order to understand possible functions of behavioural outbursts.

Develop plans relating to the functions that specific behaviours serve for the patient.



A particular behaviour may serve common functions such as:

- Establishing and maintaining social interaction with another person.
- Avoiding or escaping tasks or activities that the patient dislikes.
- Obtaining special stimulation (e.g., going for a walk, listening to music).
- Communicating to others about something the patient desires or wants.

Functions of Behaviour

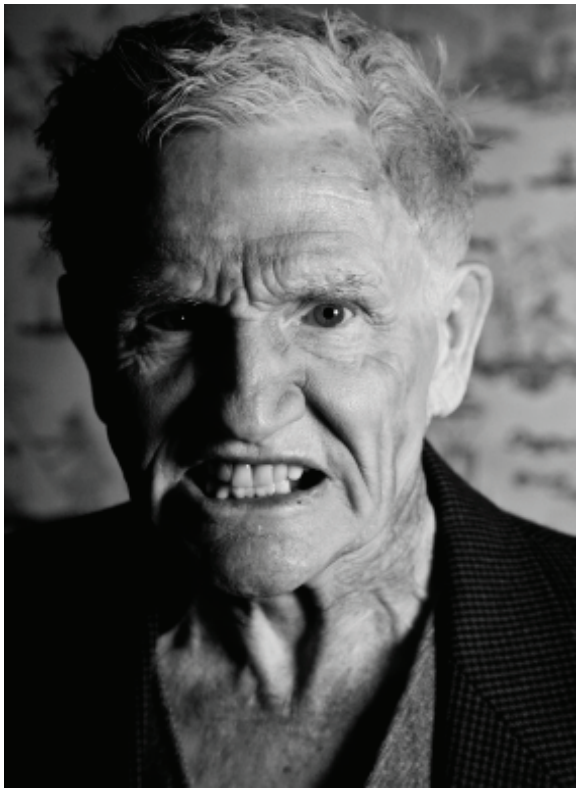
Antecedent	Behaviour	Consequence	Function
A patient is sitting in the E.D. waiting to be seen.	She is complaining and crying louder than you would expect given her assessed status at triage.	She was called to see the doctor ahead of a couple of other patients with slightly higher acuity.	Tangible
A patient keeps leaving his room every 20 minutes.	He comes over to the nursing station uses some hand sanitizer and then talks to the nurses.	The nurses engage him in conversation each time, though they eventually get irritated with the interruption.	Attention
A patient is asked the morning after knee surgery to get up and walk 10 ft. with a cane.	He starts to complain and kicks up a fuss about having to get up.	The nurse says she'll come back later and see if he will give it a try.	Escape/Sensory
A well-known patient habitually escalates and starts kicking and yelling.	Staff wrestle him to the ground and know that applying Pinel restraints usually makes him calm.	The patient calms down very quickly.	Sensory
A patient is asked to participate in a peer group to discuss some of his problems.	Frequently the patient will complain 20 minutes before the session about some mysterious pain.	He gets seen by the nurse who recommends he lie down quietly in his room.	Avoidance/Escape

An antecedent is an event that regularly precedes (triggers) a target behaviour.

Anger Management Skills

Patient's with frequent aggressive behaviours often have deficits in emotional self-control. Depending on the cognitive function of the patient, teaching the following skills might be considered when developing a comprehensive behaviour plan (see Goldstein, Glick, Gibbs, 1986 for these and other ideas):

- Knowing one's own unique physical and behavioural signs of impending anger.
- Using physical relaxation and deep breathing techniques to control physiological components of anger.
- Using positive self-calming talk when upset.
- Focusing on pleasant imagery and positive visualization when trying to calm down.
- Thinking about short and long-term consequences of aggression.
- Looking at the situation in objective terms, from other's point of view.
- Taking a "time-out" from the situation until calm.
- Verbally negotiating with others when in conflict ("talking the problem out").
- Double-checking the validity of angry thoughts and beliefs about others.



Developing Plans

Develop program plans based on information from the functional analysis of a patient's behavioural pattern. You should match a plan to each function served by specific behaviours.

Positive and Preventative Methods

Try to develop positive and preventative ways of dealing with the functions of inappropriate behaviours.

Consider the functions you have identified and attempt to accomplish the following:

- Provide structured attention and social stimulation to the patient on a regular basis, even if it is for a short period of time.
- Minimize the patient's frustration while doing required tasks.
- Choose tasks/activities the patient enjoys and minimize disliked tasks/activities.
- Structure the environment so desired leisure activities are more readily available.
- Teach more adaptive ways of expressing negative emotions.
- Use augmentative communication techniques or explicit instruction to better communicate requests.

Augmentative Communication Methods

Balanced plans should include teaching the use of alternative or augmented methods of communication. Here are some examples:

- Picture exchange training.
- Talking machines.
- Picture schedules of daily activities.
- Photos of daily special events in which patient participated (review photos for orientation).
- Sign language.
- Idiosyncratic functional signing.
- Functional object pointing.
- Symbolic communication and conceptualization.
- Picture symbols.
- The development of patient communication profiles and developmental wants and needs (include verbal expression of such wants and needs).
- Any combination of the above.

Developing a Behaviour Profile

A Behaviour Profile is a biographical essay presenting a patient's most noteworthy characteristics.

Develop a profile when supporting a patient who is:
• New to your organization, has a history of aggressive behaviour and shows a recent High-Risk behaviour pattern. (This alerts staff to use the appropriate De-Escalation strategies, should the patient demonstrate aggressive/violent behaviour in the new setting).
• Currently with your organization and is not currently aggressive/violent, but has an aggressive/violent history.
• Regularly aggressive/violent and/or has poor anger management and communication skills.

Include:

- Concise information about the patient's unique behavioural patterns.
- Antecedents/triggers to inappropriate behaviours.
- Strategies and intervention techniques to manage behaviours that are escalating towards being aggressive.

Update After:

- The first incident of physical aggression or self-injurious behaviour.
- Each subsequent incident, if necessary. Include new information, including any strategy changes required and increase in frequency or intensity of behaviour.

Share:

- Updated profile information with all other staff who deal with the patient.

Developing a Behavioural Profile

The following worksheets provide an outline for developing a Behavioural Profile.

The staff most familiar with the patient (sometimes more than one staff) should complete the following pages. Be as operational as possible in your descriptions.

Familiarity Index:

1. I have some idea about the patient's behavioural patterns, but am not sure of my accuracy.
2. I am quite familiar with the patient's behavioural patterns in some situations.
3. I am extremely familiar with the patient's behavioural patterns in most situations.
4. I know the patient's behavioural patterns in all situations.

Name of Person(s) Completing Form	Familiarity Index
Circle appropriate familiarity index	1 2 3 4
	1 2 3 4
	1 2 3 4
	1 2 3 4
	1 2 3 4

Creating a Behavioural Profile

1. How does the patient best learn?

- Establish personalized teaching strategies for the patient.
- Identify opportunities for choice-making and power-sharing.

2. How does the patient best communicate?

- Establish personalized communication strategies for the patient.
- When in doubt, ***request an assessment*** or consultation with a speech pathologist who can clarify the interactions between the patient's communication and behaviour.
- ***It is important to understand the relationship between the patient's style of communication and corresponding aggressive episodes.***

Remember: Data should be collected

3. What aggressive/violent/excessive behaviours, does the patient exhibit?

- Identify all problematic behaviours and categorize them as:
  - Common Occurence
  - Sporadic Occurence (occasional)
- When documenting behaviours of serious concern that rarely occur, describe them as "highly infrequent" or "reported in the past" but not seen.

4. What are the typical antecedents (triggers) for the patient?

- Identify the antecedents and alter them, if possible, to reduce the likelihood of the patient having a similar aggressive episode.
- Watch for environmental factors that you can also alter.

An antecedent is an event or set of circumstances that immediately precedes (triggers) the behaviour.

5. What are the early warning signs indicating that the patient's behaviour is escalating?

- Identify the initial behaviours that may signal something is wrong.
- Use the Aggression Escalation Continuum (described later).

Early warning signs may include:

- Increased movement, demands and/or verbalizations.
- Decreased interaction with others (withdrawal).

6. Describe current De-Escalation strategies.

- Identify initial De-Escalation strategies for calming the patient.
- Verbal De-Escalation strategies should be attempted prior to physical intervention strategies.

7. Which behaviours can be monitored from a safe distance?

Consider requirements and prerequisites such as:

- Throwing soft objects.
- Environmental destruction such as punching walls, overturning furniture.
- Other venting types of behaviour.

Consider when these behaviours may require intervention.

8. Which behaviours require *physical intervention?*

List all behaviours that result in imminent or actual physical harm to the patient or others.

- Different types of strikes.
- Different types of kicks.
- Different topographies of strikes.

9. Describe the interventions.

Outline all intervention strategies that have been approved for staff to use with the patient during a behavioural crisis. This outline should include:

- Which strategies have worked successfully with the patient in the past.
- The roles of various team members when intervention is required.

Remember: Data should be collected

10. Describe the minimum monitoring requirements for staff.

Consider requirements and prerequisites such as:

- Time.
- Skills required, such as physical intervention skills, clinical skills, awareness of physical abilities.
- Minimum program monitoring pre-requisites and review.

NOTES

AGGRESSION MANAGEMENT

Section Four

Aggression usually does not just happen suddenly and without warning. Aggression often occurs over time and through different phases. This section of the program describes how to assess this development in terms of four phases (subtle changes, escalating, imminent, and physical aggression) in three response domains (verbal, physiological, and gross motor) and how to incorporate the findings into an understandable "Escalation Continuum."

At the end of this section participants should be able to:

1. Demonstrate a working knowledge of the phases of aggression and appropriate staff responses.

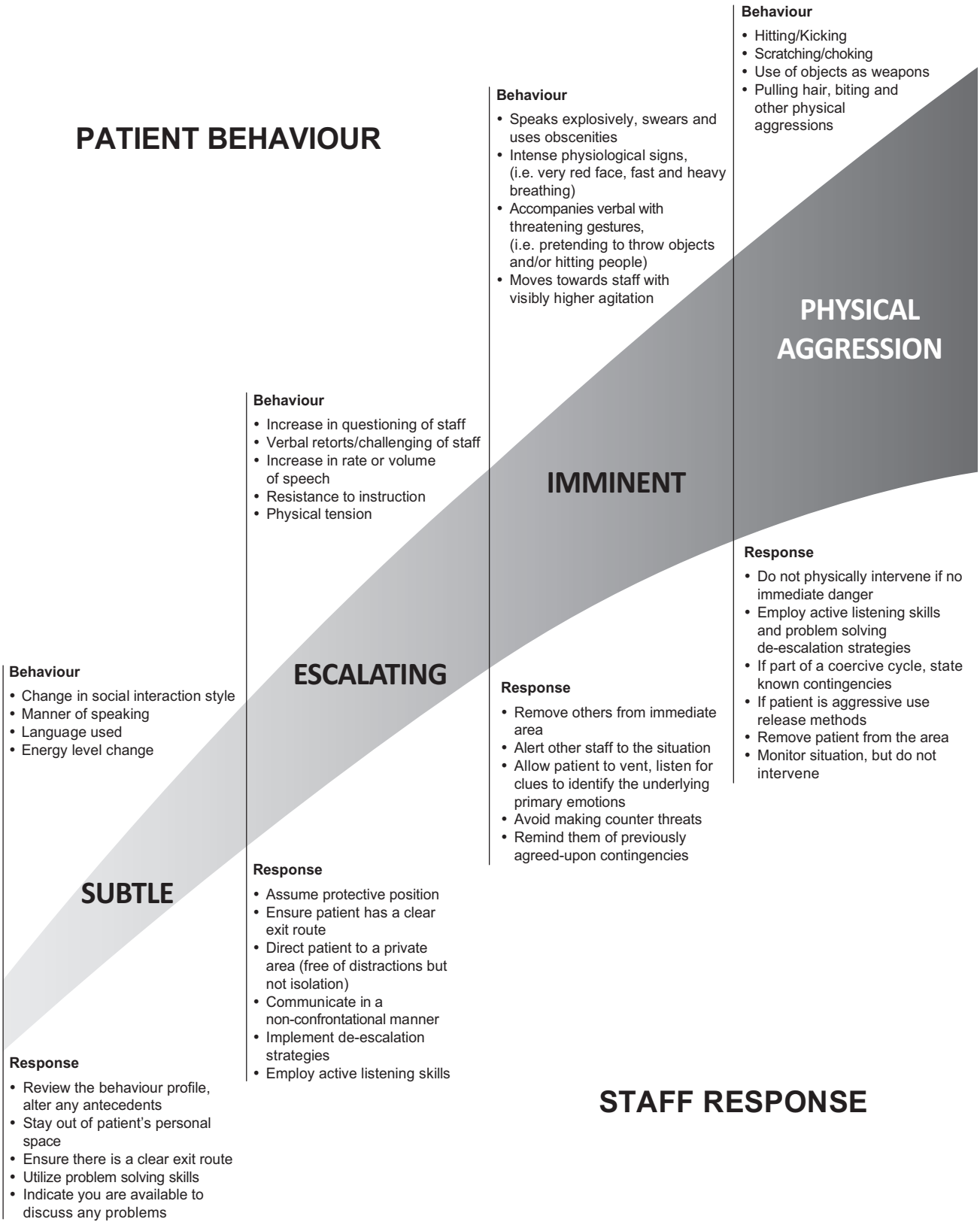
2. Apply Behaviour Profile information to the Aggression Continuum.

3. Relate the importance of effective team work and communication to De-Escalation and Crisis Management.

4. Understand the elements and importance of Debriefing following crisis episodes.

5. Identify and demonstrate knowledge of Verbal De-Escalation strategies and when physical intervention is required.

6. Identify when external supports, such as police should be accessed.



STAGE	PATIENT BEHAVIOUR	
SUBTLE	**Verbal**	Social interaction style Manner of speaking Language used
	Physiological	Change in energy level Regular behavioural patterns show change
	Gross Motor	Lethargic or manic actions (mood change) Increased pacing or limb movements
ESCALATING	**Verbal**	Increased questioning Verbal challenges Change in rate, volume and tone of voice
	Physiological	Physical tension Faster breathing Flushing of face or neck areas
	Gross Motor	Jerky movements (observable agitation) General increase (or decrease) of movements
IMMINENT	**Verbal**	Language directed towards staff Threats or warning of harm
	Physiological	Extremely fast or heavy breathing Very red face and neck area
	Gross Motor	Moves towards staff Threatening gestures (showing fist, pretending to throw).
PHYSICAL AGGRESSION	**Verbal**	All verbal behaviour accompanying aggression
	Physiological	Similar to imminent signs, possibly more intense
	Gross Motor	Kicking, slapping, throwing items, scratching. **Note:** Describe the aggression (i.e. slaps with open hands, strikes with up and down motion).

STAGE	STAFF RESPONSE	
SUBTLE	**Verbal**	Note changes in behaviour Identify triggers/problems Problem solve with patient if possible
	Physiological	Deep breathing Remain calm Present "open stance"
	Gross Motor	Stay out of patient's personal space Ensure that there is a clear exit route Have patient problem solve if able; otherwise, staff may need to assist
ESCALATING	**Verbal**	Implement known De-Escalation strategy Non-confrontational communication Active listening for emotional indicators
	Physiological	Deep breathing Remain calm Provide eye contact
	Gross Motor	Assume protective position out of patient's space Ensure that there is a clear exit route Direct patient to private area (not isolated)
IMMINENT	**Verbal**	Alert others in area, allow patient to vent State boundaries in positive manner, actively listening Do not threaten, remind of agreed-upon contingencies
	Physiological	Deep breathing and remain calm Wait for pauses in patient's behaviour to problem solve Present in a supportive manner
	Gross Motor	Assume protective position out of patient's space Remove others from area and clear exit routes
PHYSICAL AGGRESSION	**Verbal**	Alert others in area, allow patient to vent Prompt for required back-up Wait for lulls in patient's behaviour to problem solve
	Physiological	Deep breathing and remain calm Assume protective position out of patient's space
	Gross Motor	Clear others from immediate area Remember to use an approved physical intervention only if the behaviours present imminent danger

STAGE	PATIENT BEHAVIOUR	
SUBTLE	Verbal	
	Physiological	
	Gross Motor	
ESCALATING	Verbal	
	Physiological	
	Gross Motor	
IMMINENT	Verbal	
	Physiological	
	Gross Motor	
PHYSICAL AGGRESSION	Verbal	
	Physiological	
	Gross Motor	

STAGE	STAFF RESPONSE	
SUBTLE	Verbal	
	Physiological	
	Gross Motor	
ESCALATING	Verbal	
	Physiological	
	Gross Motor	
IMMINENT	Verbal	
	Physiological	
	Gross Motor	
PHYSICAL AGGRESSION	Verbal	
	Physiological	
	Gross Motor	

Developing an Effective Crisis Intervention Team

This process is not something you can choose to switch on and off as the need dictates. Safety is at stake when you intervene with a patient who is engaged in aggressive behaviour. In these situations, ***team members must have:***

1. Trust in one another;
2. Confidence in the skill levels of the other team members;
3. The same expectations;
4. Regular practice sessions; and
5. Knowledge of each team member's strengths, skills, and triggers.

Communication Prerequisites:

Your team must consistently implement mutually agreed-upon communication procedures **before, during and after** behavioural incidents.

Before	Always remain ***focused on understanding*** what others are saying to you and ***making yourself understood***. It is important to discuss the following: • Common expectations • Patient's needs • Prevention strategies • Intervention plans: non-alarming code words • Team leader and support member roles
During	***Identify the team leader*** according to pre-established criteria. Determine specific ***code words*** or gestures to determine when to: • Approach and/or begin intervention • Abort a procedure during a physical intervention • Request assistance
After	Check on each other's ***physical and emotional well-being*** Decide who will ***check on the patient's physical and emotional well-being*** Implement the ***debriefing*** process

Debriefing

Debriefing with patient(s) and staff should occur following a behavioural crisis or episode. Patient debriefing should be done once the patient is calm and able to engage in the process. The process should be seen as an opportunity to listen and reflect on the incident with the patient.

Debriefing should not involve lengthy dialogue sessions, but rather focus on providing patients, staff and management with support and functional information.

Debriefing enables team members to:

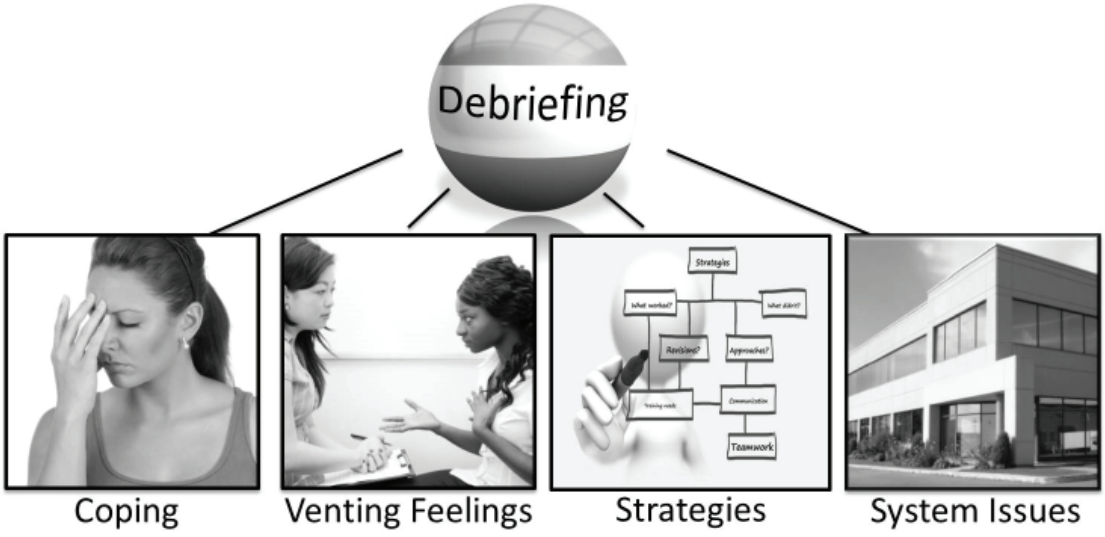
1. Review how they've been **coping** since the incident occurred.

2. Vent and share **feelings** about their involvement in the incident.

3. Identify **strategies** the team used and determine which **worked well** and/or **need to be revised.**

4. Identify any **system issues** that might assist the team in working more smoothly together.

When debriefing with staff, Safe Management recommends that stages of Coping and Venting Feelings be discussed first and at a separate time from Identifying Strategies and System Issues. It is important that staff have an opportunity to vent their feelings and share how the incident impacted them emotionally. Trying to problem-solve ineffective strategies and system concerns too soon can sometimes feel like criticism or blame.



Although every Ministry and agency/organization has their own specific Polices and Procedures regarding debriefing after an aggressive episode, the following debriefing questions/objectives are offered as possible guidelines:

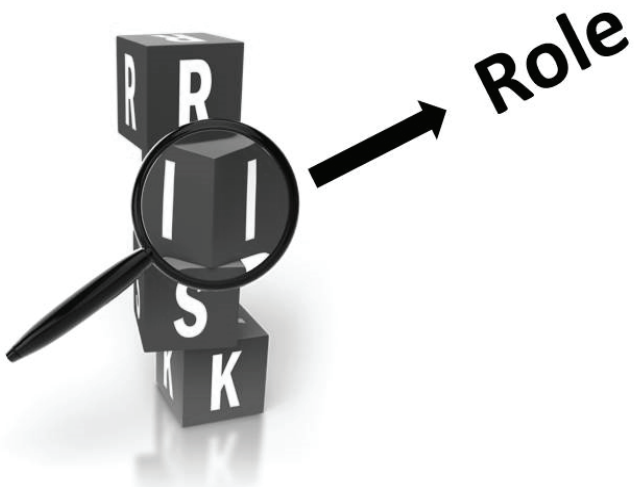
Debriefing for Staff

DEBRIEFING QUESTIONS	OBJECTIVE
What support would be most helpful for you at this moment? What about one week from now?	Identify what level of support staff require immediately as well as several days following the incident.
Is there someone in particular you'd like to talk to about the incident?	Identify with whom the staff person feels comfortable debriefing. It may be a supervisor, a colleague or an agency Trainer.
What was the impact of the incident on you?	Identify the degree to which the staff was affected by the incident.
What was the impact of the incident on your co-workers?	Obtain the staff person's perception on how well the team is coping with the situation.
Is there anything that can be learned as a result of this incident?	Determine what, if anything could be changed to prevent similar situations from occurring again.
Can you describe the situation from your perspective?	Allows the staff to explain the situation without blame or assumptions.
What did you do well in when managing the situation?	Identify what actions and strategies were effective at de-escalating or managing the situation.
If you could snap your fingers and start this shift over again, is there anything you would adjust or modify about the day (routines, actions, decisions)?	Identify, without blame what, if any, factors contributed to the situation.
How do you feel about working your upcoming shifts?	Assess the staff's state of mind and ability to function productively and effectively at work over the next few shifts.
What do you think the team needs at this point in time?	Determine next steps to ensure the team is healthy and functioning as a cohesive unit.
When is a good time for me to check-in with you again?	Allows the staff the opportunity to receive additional check-ins and support as required.

Debriefing for Patient

DEBRIEFING QUESTIONS	OBJECTIVE
Were you injured as a result of the incident? If so, do you require medical attention? Describe your experience of the situation.	Provide an opportunity for the patient to identify any injuries and the emotional aspects of their injury. Staff should support and encourage the patient to talk about their experience.
What did you do well in when managing the situation? What strategies worked?	Have the patient identify what they feel they did well in managing the situation, what strategies were effective, and what helped them calm down.
What could you have done to better manage the situation?	Have the patient identify areas where they could improve in their responses to the situation.
Is there anything that your support team could have done differently?	Have the patient identify areas where he/she felt that the staff team could have responded differently and would have been more successful in assisting the patient in de-escalating.
What did your support team do that was helpful?	Have the patient identify what strategies the staffing team used that he/she found helpful.
Was there anything that you feel made the situation worse?	Have the patient identify any environmental conditions/ antecedents that further escalated the situation.
Were physical interventions required? If yes, why?	Have the patient identify the reasons why physical interventions were used.
How can physical interventions be avoided?	Assist the patient in exploring strategies that could have been used to prevent the use of physical interventions.
What would you do differently in the future if a similar incident were to occur?	Facilitate problem solving by having the patient consider alternative strategies and responses to similar situations in the future.
Do you feel changes in your support plan need to be made?	Discuss the patient's intervention plan and determine if changes need to be made in the patient's plan. Encourage the patient to take an active role in reviewing their current intervention plan and discuss areas for change/revision.
Do you need any additional services/supports?	Support the patient in reviewing and determining whether he/she feels they require additional supports or services, e.g., counselling, anger management, social supports. Provide resources and information to the patient based on identified needs.

When to Physically Intervene



NEVER

Rush into a situation.

ALWAYS

Walk in calmly and slowly while evaluating the situation to determine what role you should assume.

When arriving on scene, consider the following:

Has someone assumed the crisis leadership role?

Is the staff in the leadership role in control emotionally and physically?
If not, who is the best person to assume this role?

Have support staff been called?

When to Physically Intervene

Does 911 need to be called?

Has injury occurred to anyone involved? If so, is medical attention required?

Are others in the area at risk. Can they be moved out of harms way and monitored?

Can the patient involved in the crisis be monitored from a safe distance?

Are too many staff escalating or overwhelming the patient?

Are there properly trained staff available and ready to assist?

Are there weapons, or any items that could be used as potential weapons in the immediate area? If so, can they be safely removed?

When to Physically Intervene

Once you have acquired self-protection skills, you need to learn **WHEN** to use physical intervention and **WHEN** to refrain from using it.

Always refer to a patient's Behavioural Profile.

Ask Yourself:

- Does the situation or the patient's behaviour meet the threshold of **Imminent Risk of Harm to Self or Others?**
- Can I monitor the patient's behaviour from a safe distance?
- Can I, or have I, given the patient adequate time to calm down on their own?
- Can I, or have I, allowed the patient to vent; have I actively listened to their concerns?
- Have I considered the 7 Relationship Management principles and have I tried to correct any imbalances?
- Have I attempted any verbal de-escalation strategies?
- Is there another staff available that has a better rapport with the patient?
- Am I calm?
- Am I letting my emotions negatively influence my actions?

Responding to Weapons

Dealing with crisis can be challenging, unpredictable and anxiety producing. One of the most volatile and stressful situations staff can experience is an aggressive patient with a weapon. Safe Management Group DOES NOT RECOMMEND that staff intervene physically in an attempt to remove a weapon from an aggressive patient. Safe Management does not endorse, promote or train the use of physical interventions when weapons are involved. Most importantly, the risk of injury to staff, the patient and others is far too great.

In all cases where weapons are involved, the use of Police intervention is encouraged. The Police have a different mandate and specialized skills and tools to deal with weapon use.

Where possible, staff should utilize the **RESPOND** acronym until police arrive.

Weapons "RESPOND" Approach

R **Relationship Management**

Power & Equity - Respect the person and the severity of the situation – At this moment, the aggressive patient has the power. They need to know that they are in control and you are only there to help.
Empathy Caring and Acceptance – Actively listen to the patient's needs. P.A.E. (Pay Attention, Acknowledge, Encourage).
Genuineness and Openness – Ensure your words and non-verbal messages are communicating a genuine sense of wanting to help.
Responding to Emotions – Assess and gauge the intent behind the action. Is the weapon a fear-based response? Is there real intent to harm others? What does the patient need or want? Can you meet those needs?

E **Emergency Response**

Call 911. Clearly state that a weapon is involved. This will assist dispatch in assigning a higher level code to the situation and will influence the Police response. Initiate internal crisis response protocol.

S **Stay Calm**

Your calm approach will influence the aggressive patient. Speak softly and slowly. Focus on diaphragmatic breathing.

P **Protective Position**

Assume Protective Position and increase the distance between you and the aggressive patient. If possible, close doors and contain the patient in a room or area that allows for observation.

O **Others**

Manage others in the vicinity. Staff, patients, family members, etc. may exacerbate the situation. If necessary, remove others. Too many staff may threaten the aggressive patient and lead to the weapon being used. Other patients may encourage weapon use or may be fearful, which only adds to the intensity of the situation.

N **Negotiate**

Keep the patient focused on you. Ask questions like, "How can I help?" or "What do you need?" Answer "yes" to as many questions from the aggressive patient as you can. The more "yes" answers, the more probability the person will De-Escalate.

D **Do Not Physically Intervene**

Attempting to physically intervene when a weapon is involved puts you, others and the patient at risk of severe injury.

De-Escalation Checklist

A. GENERAL BEHAVIOUR

- ⧈ Do not crowd the patient
- ⧈ Be aware of environment (noise level, location of others, escape routes, etc.)
- ⧈ Be aware of Aggression Escalation Continuum and use it effectively
- ⧈ Determine objectives to be achieved during discussion
- ⧈ Maintain eye contact, when appropriate
- ⧈ Be firm and assertive, as required
- ⧈ Implement follow-up, as discussed with patient

B. CALMING BEHAVIOURS

- ⧈ Use simple words
- ⧈ Voice is soft, slow and clear
- ⧈ Face and body are relaxed
- ⧈ Ask brief, open-ended questions
- ⧈ Listen carefully to what the patient is saying (aphasia can lead to misunderstanding)
- ⧈ Report (paraphrase) what you hear the patient is saying
- ⧈ Concentrate on one issue/topic
- ⧈ Allow the patient to finish what he/she is saying
- ⧈ Identify/clarify the patient's feelings
- ⧈ Use silence appropriately - allows the patient to initiate - elderly people will take longer
- ⧈ When appropriate, use distraction to focus the patient's attention on another task (drinking water, breathing exercises, washing face, etc.)
- ⧈ Summarize/clarify your understanding of the patient's perception of the problem
- ⧈ End discussion when De-Escalation has occurred (not necessarily when problem is actually solved). Problem solving can occur at another time when the patient is calmer

C. DEFUSING BEHAVIOURS - Use all of the general and calming behaviours listed above, as well as the following:

- ⧈ Reinforce signs of De-Escalation (energy drops, breathing slows down)
- ⧈ Work as a team, if other staff are available
- ⧈ Leader gives clear directions to team members
- ⧈ Let the patient know that others are there to assist him/her, not to confront
- ⧈ Give the patient more space if needed
- ⧈ Use concrete words
- ⧈ Encourage the patient to engage in alternate behaviour
- ⧈ Remind the patient of consequences by stating facts, not threats

PHYSICAL INTERVENTION CONCEPTS

Section Five

This section provides preliminary information relevant to learning the Safe Management Group's Physical Intervention Techniques. We review MCSS requirements for training and implementing emergency physical interventions. These requirements offer a set of quality control guidelines that should be considered in all settings.

At the end of this section participants should be able to:

1. Understand Safe Management's teaching approach.

2. Understand how physical intervention, based on biomechanical technology, is integrated into Safe Management Group's curriculum.

3. Identify methods of guaranteeing safety for patient's learning and practicing Safe Management Group's Physical Intervention Techniques.

4. Have a strong knowledge and concrete implementation of self-protection and physical containment techniques.

Safe Management's Teaching Approach

Our approach in teaching advanced physical intervention methods, such as physical restraints, focuses on safety in training and safety in implementation. To this extent, different quality assurance tools have been developed to help agencies maintain a high level of Risk Management and staff competency across time.

Advanced vs. 2-Day Training

Advanced physical intervention methods are not taught as part of Safe Management's Crisis Intervention Training. They are only taught to staff who work with severely aggressive/ violent patients and who have attended Safe Management's Crisis Intervention two day Training. Many advanced physical intervention methods are often misunderstood by laypersons. Before any front-line training takes place, senior consultants work closely with an agency/ organization's management-level representatives to explain our training approach and methods. The training requirements for physical restraints and other advanced physical intervention techniques are very complex and ***must be customized to each patient.*** As a result, not all advanced methods are taught to each agency. The Safe Management best practice process for developing physical restraints is illustrated in the Patient Specialized Consultation Technique Development Process.

For example, a ***"general restraint" technique would not adequately address the unique aggression topographies of each patient.*** All advanced intervention techniques must be customized to reflect specific implementation angles, body part placement, branching procedures and the physical ability of the staff. During the real-life simulation component of our training, we draw extensively on the Behavioural Profile and physical aggression topography analysis of the patient to enhance the value and impact of the training process.

All manuals use a patented method of integrating text with photographs. This approach is illustrated in our Instructor/Advanced manual, in the section titled "Physical Techniques".

These pages illustrate the basic escort, containment and restraint techniques that form the basis of most of Safe Management's Advanced Physical Intervention methods. We will provide, upon request, a more detailed example of a customized Advanced Physical Intervention reference manual.

Technology

The ***physical intervention technology is a biomechanical technology*** designed to teach people how to execute body movements efficiently and effectively, in order to prevent injury. It refers to the ***application of concepts related to angles, movement recognition, body control, aggression topography profiling and aggression response styles.***

Developing cutting edge self-protection and containment techniques, based on martial arts biomechanical technology, **does not necessarily make the techniques dangerous or unacceptable.** The way these techniques are developed, taught and applied (a multi-factor approach) determines whether they are dangerous or safe.

To be safe and effective, ***physical intervention techniques must be designed, taught and applied within a properly developed and monitored agency infrastructure.*** To this extent, Safe Management's approach involves training needs assessments and careful customizing of training packages to meet your short and long term needs. Safe Management's physical techniques do not place pressure on joints, hyper-extend joints or use pressure points.

Safety for Patient

Consideration to implement physical intervention techniques with a patient should be based on the following safety critical information. Appropriate Risk Management must be the core focus of any procedure involving physical intervention techniques.

Physical Well-Being

- Patient has ***no medical conditions*** that preclude the use of physical intervention procedures. Such medical conditions may include, heart condition, history of back problems, respiratory problems, bone density issues.
- Possible physical ***risk conditions*** should be listed, (e.g., overweight, asthma, hay fever/other allergies, easily bruised, etc.)
- Recent ***physical injuries*** should also be noted as well as severe injuries or surgeries experienced in the past.
- ***Medication's impact*** on safety of physical interventions should also be addressed with a physician.
- A ***physician*** should provide written documentation on whether there are existing medical conditions preventing safe implementation of physical intervention techniques.

Clinical Information

- A ***Behavioural Profile*** should be completed on the patient.
- ***Depending*** on a patient's diagnosis, appropriate professionals should be consulted on the role of psychiatric illness and/or neurological factors related to the patient's physical aggression.
- ***Obtain information*** related to possible antecedents.
- ***Topographical*** analysis should also be completed on the patient's physical aggression techniques, e.g., the dominant hand the patient uses to strike or which type of strike the patient most uses.
- ***Physical aggression*** "success ratio" needs to be determined as part of the risk assessment.

Operational Factors

- Information related to the ***physical well-being of staff,*** who will be implementing physical interventions, needs to be available, (e.g., recent injuries, fitness level, physical/medical limitations, etc.)
- Has staff taken necessary ***training***?
- Is there information available on the ***level of competency*** demonstrated by staff during training?
- Is the location staffed appropriately for safe implementation of physical intervention procedures? (e.g., is there a large difference between the patient's size and strength and that of that staff members? Is there an appropriate staffing ratio to safely carry out physical intervention procedures? Are the same staff consistently on?
- ***PRN, evacuation and 911 procedures in place?***

Safety for Participants

The following safety critical procedures are necessary to ensure safety for participants during training sessions in physical intervention techniques.

Physical Well-Being

- Participants must ***have no medical conditions*** that prevent them from participating fully in the training sessions (e.g., heart condition, history of back problems, recent fractures, recent leg sprains).
- The course ***instructor must be told of all medical conditions*** before the training sessions.
- Participants need to have opportunities to drink fluids once every half hour during extended intense training sessions involving intense physical exertion.
- ***Windows and doors must be opened*** in non-air conditioned rooms.
- Participants must always ***stretch and warm-up*** when learning physical techniques. ***A cool down period*** at the end of physical activity should also occur.

Clothing/Environment

- Participants must not wear jewelry or have any extra items attached to their clothing (e.g., pens, keys).
- Participants should wear ***loose, comfortable clothing.***
- Participants should wear appropriate, ***flat-heeled, non-slip soled shoes***.
- When training in a carpeted room, ***participants should be regularly reminded to lift their feet when they move.***
- ***Furniture must be moved well away*** from participants.

Training

- Always follow the **Model, Explain, Imitate,** and **Consolidate** teaching approach:

Model - slowly demonstrate each movement in a physical technique.
Explain - articulate and demonstrate each technique at least three times.
Imitate - have participants slowly imitate the movements.
Consolidate - have participants practice slowly, then with increasing speed, as coached by the instructor.

- Consistently implement a shaping procedure to help participants acquire a skill.
- Consistently maintain structure and discipline (e.g., discourage doing techniques at high speed without instructor approval, discourage horseplay).
- Use the “Paired entity” approach. Participants, when paired together, learn to give feedback and reinforce each other’s learning.

Positional Asphyxia

Positional asphyxia, also known as postural asphyxia, is a form of asphyxia which occurs when a patient's physical position prevents them from breathing adequately. Research has suggested that restraining a person in a face down position is more likely to cause greater restriction of breathing than restraining a person face up.

Safe Management Group Inc. recommends staff only consider physical restraints if;

• It is determined that less intrusive intervention has been attempted and has been ineffective;
• There is a clear and imminent risk that the patient will physically injure themselves or others;
• The techniques are carried out using the least amount of force necessary to restrict the patient's ability to move freely;
• While under restraint, the patient's condition is continually monitored and assessed;
• The restraint is stopped when there is a risk that the restraint itself will endanger the health or safety of the patient;
• Physical restraints have been integrated into a Behaviour Support Plan;
• Staff have received training regarding the safe use of the physical restraint intervention.

Signs of Distress

It is imperative that a patient is monitored while in a physical restraint. Risk factors such as obesity, prior cardiac or respiratory problems and how a patient is restrained can add distress to a patient.

The following are some signs that a patient is in distress:

- Rapid, shallow breathing
- Panting
- Grunting
- Blue tinge to nail beds and/or around the mouth
- Nasal flaring
- Sudden slowing of breath

Safe Management's Physical Intervention Techniques ensure the following conditions DO NOT occur:

- Severe pressure or weight on chest, sternum or diaphragm areas.
- Methods causing severe chest compression (i.e. positional compression).
- Positional configurations causing breathing distress.

Basic Position

Used at all times

- Keep a step and a kick length away from the patient
- Body at a 45 degree angle to patient
- Feet shoulder width apart
- Hands up and above the waste in a non-threatening manner

Protective Position

Used when patient is in the imminent phase

- Increase distance from patient
- Maintain Basic Position
- Forward am matches forward leg; other hand up
- Arms at 90 degrees
- Arms are appropriate distance from core
- Hands are open, palms turned slightly out in a non-threatening manner (fingers and thumb together, ensuring clear sight lines)
- Ensure hands do not block vision

Movement

- Awareness of environment and exits
- Maintain Protective Position
- 'Train Track' concept.
- Shuffle Step - front foot pushes off for backward movement; back foot pushes off for forward movement
- Pivot Step - pivot on ball of foot (door hinge concept)
- Maintain balance throughout movement

Straight
Used for redirection/deflection/blocking

- Avoidance Strategies
- Mirror image (ideally), arm and body move as one unit
- Palm turned out, fleshy part of arm exposed
- Pivot on balls of feet
- Deflect the strike between wrist and elbow; do not push
- Maintain a visual of patient/Awareness of further aggression

Two Handed Lunge
Used to prevent chokes/grabs/hair pulls/shoves

- Similar to straight strike
- Pivot to either side. Let environment dictate

Roundhouse
Used for blocking strikes from the side

- Avoidance Strategies
- Block first, move only when safe
- Mirror image
- Arm at 90 degree angle with palm turned out
- Meet the strike, do not push
- Awareness of further aggression

Overhead
Used for blocking strikes coming from above

- Block first, move only when safe
- Mirror Image - ideally
- Forearm in front, above head at 45 degree angle
- Palm turned up and out, fleshy part of arm exposed
- Absorb impact with lower body (knees bent)
- Reinforce with other hand, palm to the back of hand if necessary
- Awareness of further aggression

One on One

- Least intrusive first (e.g., “Please let go”)
- Step in; set feet up in direction of weak point
- **Tuck** - your elbow to your waist/trunk
- **Turn** - your wrist to the thinnest profile
- Reinforce or block with other hand, if necessary
- **Twist** - your whole body towards the weak point (feet, hips, arms and shoulders move as one unit)

Two Hands on One Wrist

- Least intrusive first (e.g., “Please let go”)
- Step in and tuck elbow; set up feet for rotation; arm and leg match
- Make a fist and grab it with the other hand
- Raise hands enough to clear patient’s forearms
- Pull up through weak point, rotating towards back leg
- Do not pull hands up towards your face

Two on Two - from the Front

- Least intrusive first (e.g., “Please let go”)
- Step in and tuck elbows
- Thrust your palms up and out
- Do not pull hands towards your face

Two on Two - from the Back

- Least intrusive first (e.g., “Please let go”)
- Step back
- Place your fists on your waist
- Elbows must be out to the side, not pointed back
- Step forward and straighten arms out to the front

Managing Clothing Grabs - from the Front

- Avoidance Strategies (Proximity/Positioning/ Appropriate clothing)
- Least intrusive first (e.g., “Please let go”)
- Contain clothing between patient’s hand and staff’s body with the appropriate hand
- Cup with your free hand close to patient’s fingers
- Elbow tucked
- Guide/Rotate through to release

Managing Clothing Grabs - from the Back

- Grab your clothing from the front at appropriate height
- Tighten the clothing by pulling your clothes forward
- Take a step forward and pivot towards the patient to release clothing

One Hand or Two Hands from the Front

- Avoidance Strategies (Proximity/Positioning/ Appropriate hair style)
- Contain the patient's hand(s) to your head (hand-over-hand; no pressure on the knuckles)
- Step back (away from patient)
- Widen stance to lower body (back straight, knees bent)
- Keep elbows in (for strength and protection)
- Call for assistance

Worm Release

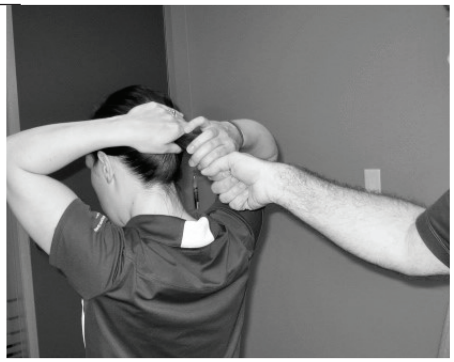
- Help to contain the patient's hand(s)
- Remove staff's hands (as required) to expose patient's thumb
- Worm thumb in
- Lever up
- Block during release
- Communicate exit directions to staff

From the Back - One Hand

- Contain the patient's hand(s) to your head (hand-over-hand; no pressure on the knuckles)
- Elbows in (for strength and protection)
- Call for assistance
- Determine which hand the patient is using (feel for thumb)
- 3 steps – inside leg steps back and beside the patient, step parallel, lower your body as you turn and face the side of the patient's leg (in line with seam of patient's pants)
- Raise up slightly to lift the patient's arm to a 90 degree angle

Straight Hair Ponytail

- With one hand, contain the base of the pony-tail
- With other hand, grasp above the patient's hand and slide it down
- Gather hair into containment hand, if necessary
- Repeat until free



From the Back - Two Hands

- Contain the patient's hand(s) to your head (hand-over-hand; no pressure on the knuckles)
- Keep elbows in (for strength and protection)
- Step back towards the patient in a balanced stance
- Roll shoulders forward in a controlled manner
- Do not hyper-extend patient's elbows
- Call for Assistance

Chokes - from the Front

- Avoidance Strategies (Proximity/Positioning)
- Tuck Chin
- Raise both arms (elbows higher than patient's forearms)
- One foot steps back
- Twist towards back leg/your core

Chokes - from the Back

- Tuck Chin
- Raise both arms (elbows higher tha patient's forearms)
- 'Mark' with one foot back
- Rotate on toes towards marked foot

Forearm Choke

- Cup over forearm
- Pull down and drop body weight if needed
- Tuck chin inside of patient's forearm
- Step back with leg closest to the patient's hand
- Turn head in towards patient's body
- Continue to pull head free

Bites

- Avoidance Strategies (Proximity/Positioning/PPE)
- Contain back of head
- “Feed the bite”
- Call for assistance
- Release (“J-roll”) when bite loosens
- Seek medical attention immediately

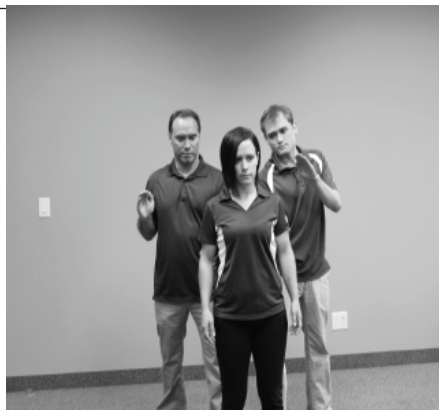
Kicks

- Avoidance Strategies (Proximity/Triangle concept)
- Turn body 90 degrees to the patient
- Lift front knee straight up - foot is parallel to the floor
- Arms up to protect core
- Block the kick with the bottom of your foot
- Landmark on or near the top of the patient’s foot
- Do not kick out
- Reposition to maintain balance once kick is blocked

Stage One Escort

Used to support/guide a non-resistant patient

- Line up shoulder behind patient's shoulder
- Position hand on the patient's arm, just above the elbow
- Tuck your arm to the front of your body to avoid swatting
- Other hand to support or block as required



Stage Two Escort

Used to support/guide a patient presenting low to moderate resistance

- Grasp patient's wrist with outside hand (underhand grip)
- With inside arm, reach through and overtop patient's forearm; grasp your own wrist
- Prompt arm back into your armpit
- Move slightly behind patient
- Prompt patient forward with upper body

Stage Three from Stage Two

Used to contain or guide a patient presenting moderate to high resistance

- Outside hand continues to secure patient's wrist
- Prompt patient's arm back
- Inside arm dives in and wraps around the patient's waist
- Pull in at patient's waist
- Walk forward or remain stationary
- Be aware of possible head butts

Stage Four from Stage Three

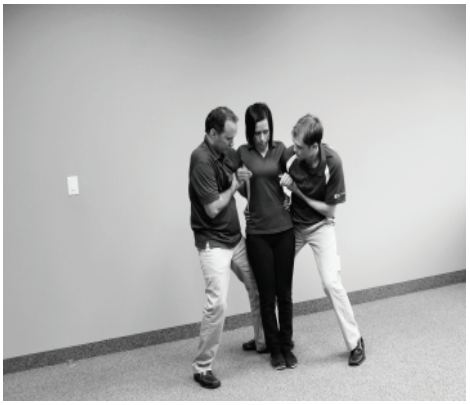
Used to safely manage a patient presenting severe resistance

- Inside leg moves behind the patient's knees, legs overlap
- Maintain a balanced stance
- Staff turn slightly towards each other, hips tight against patient
- Tuck elbow to prevent bites and head butts as needed
- Tilt hips forward, if needed, to reduce patient's strength

Stage Four Containment (Alternate Approach)

Used to contain a patient displaying behaviour that requires immediate intervention to manage clear and imminent risk of harm to self or others

- Communicate approach with partner
- Move in at 45 degree angle with in Protective Position
- Block on upper arm/shoulder
- Slide one hand down to wrist
- Prompt patient's arm back
- Inside arm dives in and wraps around patient's waist
- Inside leg moves behind the patient's knees, legs overlap
- Maintain a balanced stance
- Staff turn slightly towards each other, hips tight against patient
- Tuck elbow to prevent bites and head butts as needed
- Tilt hips forward, if needed, to reduce patient's strength
- Third staff as barrier if necessary (do not hold patient's head)



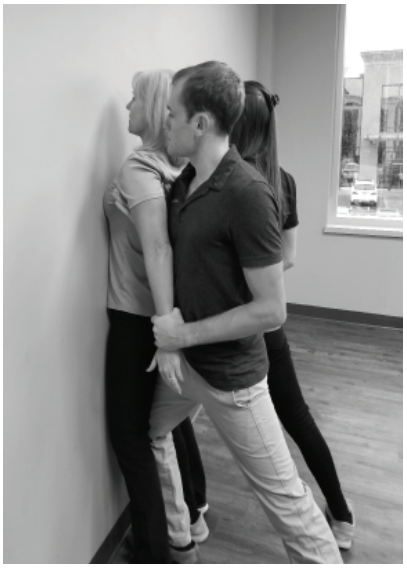
Modified Escort

Must meet the threshold of imminent risk of harm to self or others

- Communicate approach with partner
- Grasp patient's wrist with outside hand
- Slide inside hand up to patient's armpit (fingers facing forward with thumb up)
- Apply upward pressure into patient's armpit while pulling down slightly on patient's arm
- Line up shoulder behind patient's shoulder (closed stance)
- Escort in a swift and controlled manner
- **DO NOT RAISE OR PULL BACK ON PATIENT'S ARM**

Wall/Corner Containment One (from Modified Escort)

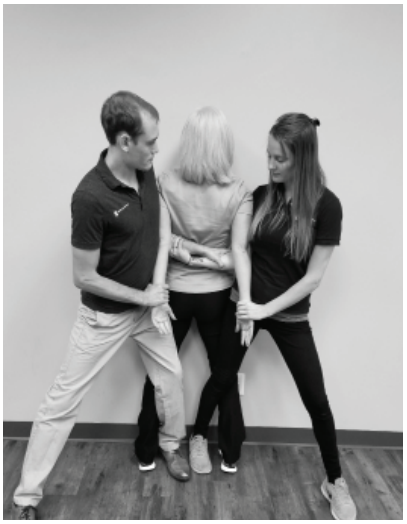
Must meet the threshold of imminent risk of harm to self or others



- Communicate approach with partner
- Grasp patient's wrist with outside hand
- Using Modified Escort, move patient to a wall or corner, free from obstacles
- Use least amount of force required when placing patient against wall
- Maintain the same arm position as the Modified Escort
- Place inside leg between patient's legs (ideally)
- Compress the patient against the wall using hips
- **ENSURE PATIENT'S SAFETY IF HEAD-BANGING ON WALL**
- **DO NOT RAISE OR PULL BACK ON PATIENT'S ARM**

Wall/Corner Containment Two (from Modified Escort)

Used to contain a patient who cannot be safely managed using Wall Containment One



- Communicate approach with partner
- Using Modified Escort, move patient to a wall or corner, free from obstacles
- Use least amount of force required when placing patient against wall
- Wrap outside arm in-front and around patient's arm, staff join arms together behind patient's back
- Inside hand secures patient's wrist
- Staff turn inward to face each other with inside leg directly behind patient - hips tight against patient
- **ENSURE PATIENT'S SAFETY IF HEAD-BANGING ON WALL**

APPENDIX

Section Six

Aggression

Verbal or physical acts such as loud yelling or threatening, hitting, kicking, punching, biting, etc.

Agitation

An emotional state of heightened arousal and anxiety that often occurs in the early stages of an aggressive escalation.

Arousal vs. Anxiety

Arousal involves a heightened physical state caused by the release of adrenaline characterized by autonomic nervous system responses such as muscle tension, increased respiration rate, increased heart rate, pupil constriction, etc. Anxiety is a more intense state of arousal also involving panicky feelings and worry about catastrophic events.

Biomechanical Problem Solving

Teaching potential trainers how to identify the types of injuries that could occur in improper implementation of basic self-protection skills and containment / restraint techniques.

Confine

To place a patient into an enclosed area from which escape is not permitted.

De-Escalation

A process of reducing a patient's level of arousal during an aggressive escalation.

Entity Concept

Safe Management views a group of training participants from an "entity" framework. Two participants make up an "entity". Seasoned Safe Management instructors can instruct groups of 10 "entities". Participants in an "entity" acquire skills in working with each other, e.g., picking up cues on what their partner did correctly or incorrectly. Participants also learn to provide positive and constructive feedback during practice with each other.

Intrusive

Interventions that involve confinement or physical restraint.

Physical Restraint

Using a holding technique to restrict a patient's ability to move freely.

3-Section Body Calibration

Participants training to be trainers are taught how to help workshop participants problem-solve difficulties in acquiring new physical techniques. A basic problem-solving skill is the ability to observe if any incorrect or problematic physical movement is occurring in the following body sections, bounded by the following:

- Top of the head to the bottom of the neck.
- Shoulders to hip area.
- Bottom of the hip to the bottom of the feet.

Inappropriate movements in each section are corrected one section at a time.

Topography

The form which behaviour takes, e.g., hitting, spitting, running, biting.

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Test marks to be submitted to Safe Management Group Inc.

SAFE MANAGEMENT GROUP - BASIC CRISIS INTERVENTION TEST

Name:	Agency:
Contact Number:	Date:
Email Address:	Percentage/Score: /26

Multiple Choice: Please circle the correct response, for each question.
Participants taking the 1/2 day program, please complete questions 1-9 only.

1. A "Predictable Crisis" involves an incident of aggression:

a. By a patient who rarely, if ever, has any aggressive outbursts.

b. In which medical and organic factors play a primary role.

c. By a patient with a well documented history of aggressive behaviour.

d. In which the patient verbalizes intent to aggress.

2. When interacting with others, it's important to consider both verbal and non-verbal communication. In this course it was identified that non-verbal communication (body language, facial expressions, voice tone) makes up _____% of communication, while words make up _____%.

a. 90; 10

b. 93; 7

c. 80; 20

d. 60; 40

3. The best way to correct an imbalance of power in a relationship is to?

a. Assess the number of positive versus negative interactions.

b. Provide more opportunities for choice and autonomy.

c. Use Active Listening.

d. Ensure that consistency between staff is maintained.

4. When considering the four stages of the Aggression Escalation Continuum, where should staff attempt to focus their intervention attempts?

a. Physical Aggression Stage

b. Subtle Stage

c. Imminent Stage

d. Escalation Stage

Test marks to be submitted to Safe Management Group Inc.

5. **The Relationship Management principle of "Reading and Responding to Emotions" promotes 2 distinct phases. Phase One involves Active Listening. Phase Two involves the Four Stages of Problem Solving. These stages are:**

   a. Identify the problem; Brainstorm ideas; Weigh options; Implement the plan

   b. Listen; Gather; Respond; Direct

   c. Label feelings; Actively listen; Plan; Take action

   d. Consider options; Explore solutions; Negotiate outcomes; Activate the plan

6. **The Active Listening acronym promoted in this course is P.A.E. The E stands for:**

   a. EXPRESS emotions

   b. ENCOURAGE more conversation

   c. ELICIT a response

   d. ENFORCE expectations

7. **In addition to describing a patient's stages of escalation, the Aggression Escalation Continuum should also be developed to describe:**

   a. Recommended staff responses to each of the patient's escalation stages.

   b. What the patient should not do in each of the escalation stages.

   c. The number of hours staff are required to work.

   d. None of the above.

8. **The most successful approach in developing a Safe Environment is to focus on:**

   a. Admitting non-violent patients

   b. Providing staff training in the most effective containment methods

   c. Prevention

   d. Developing an Aggression Escalation Continuum for the patient and applying graduated intervention techniques.

9. **The Aggression Escalation Continuum identifies levels of aggression using 3 response domains. These domains are:**

   a. Verbal, Psychological and Physiological

   b. Gross Motor, Physical Aggression and Body Language

   c. Words, Emotions and Actions

   d. Verbal, Physiological and Gross Motor

10. **Verbal De-Escalation Techniques are an effective initial strategy to help prevent an escalation in an patient's behaviour. Please choose the answer that best describes Verbal De-Escalation Strategies.**

    a. Providing staff implement De-Escalation Strategies effectively, they will work on all patients.

    b. Staff must be ready to use a variety of De-Escalation Strategies dependent on the person and the behaviour.

    c. Staff should become proficient in two or three effective De-Escalation Strategies and use them consistently.

    d. When all else fails, humour may be the best strategy to attempt.

Test marks to be submitted to Safe Management Group Inc.

11. Threatening a patient with additional consequences in an attempt to gain compliance is an example of _____.

a. Effective De-Escalation

b. Consistency

c. Coercion

d. Establishing guidelines

12. An effective Behavioural Crisis Intervention Team must have TRUST in one another, CONFIDENCE in each other's skills and abilities, the SAME EXPECTATIONS, KNOWLEDGE of each member's strengths and potential triggers and _____.

a. Camraderie

b. Cohesiveness

c. Regular practice sessions

d. Physical size

13. When we say that a behaviour serves a function in the patient's environment, we mean:

a. The behaviour occurs because of internal biological functional factors.

b. The behaviour is maladaptive and, is therefore, dysfunctional.

c. The behaviour occurs to get the patient something they want or need.

d. The behaviour can be altered by changing the environmental contingencies.

14. From a functional perspective, aggressive behaviours can be reduced:

a. When staff ignore small behaviours that may escalate.

b. When boredom is minimized.

c. With appropriate profiling of patients.

d. When patients are given more free time.

15. When arriving in a situation where another staff member is dealing with an escalated patient, one should:

a. Rush in and immediately offer assistance.

b. Walk in calmly to assess risk and next steps.

c. Immediately call the Police for assistance.

d. Immediately yell for help.

16. A Physical Restraint procedure is terminated when the patient:

a. Says he/she is calm.

b. Indicates remorse for the inappropriate behaviour.

c. Stops resisting and agrees to staff's expectations.

d. Is no longer a clear and imminent risk of harm to self or others.

Section Two: True or False
Please indicate the correct answer, by circling the "T" - True or "F" - False.

1.	Safe Management Group promotes the "RESPOND" approach when dealing with a patient with a weapon. The "D" in RESPOND stands for "DISTANCE".	T	F
2.	Prior to using physical restraint, staff must be able to articulate that other, less intrusive interventions were first attempted.	T	F
3.	A patient who speaks explosively, or swears and uses obscenities, accompanied by threatening gestures is more likely in the Imminent Phase of the Aggression Escalation Continuum.	T	F
4.	A patient who aggresses in response to an undesirable demand or task may be engaging in coercive behaviour.	T	F
5.	Safe Management takes responsibility for incorrect use of its procedures.	T	F
6.	Participants in Safe Management training must share with their manager and/or trainer if they have any physical limitations that might prevent them from fully participating in the training.	T	F
7.	The Relationship Management Principle of Empathy, Caring and Acceptance promotes that staff use the skill of active listening.	T	F
8.	A patient who is truly in the PHYSICAL AGGRESSION phase of the Escalation Continuum is still able to be rational.	T	F
9.	When a patient displays anger, it is imperative that staff use assertive language to gain control of the situation.	T	F
10.	When debriefing with staff, it is important to deal with preventative strategies prior to allowing the staff the opportunity to vent and cope with the situation.	T	F

PLEASE READ CAREFULLY

As a participant in the SMG Crisis Intervention Training Program, you will be involved in practicing intervention strategies. Please be advised that some of these methods involve physical contact and may include risk of injury. It is important that you follow the exact directions of your Instructor.

Safe Management Group Inc. makes no warranty or representation that the skills, techniques, and methods taught in this program comply with all local laws, rules, regulations, and ordinances that may be applicable to persons utilizing same. Safe Management Group Inc.'s Physical Intervention Techniques should be used in a manner that is in compliance with local laws and regulations. Safe Management Group Inc. assumes no liability whatsoever for any bodily injury, loss, damage or any related claims caused by the misuse or incorrect application of the skills, techniques, and methods taught in this program, as a result of any undisclosed medical condition or by illegal or inappropriate use of same, whether or not such injury, loss, or damage is foreseeable.

SAFE MANAGEMENT TRAINING EVALUATION

Please take a few minutes to answer the following questions about our Crisis Intervention Training. Your feedback is important and will aid us in the future development of our training products.

Please rate the following: 1=Strongly disagree 2=Disagree 3=Neither agree nor disagree 4=Agree 5=Strongly agree	**RATING**				
The instructor presented the information in a clear and concise manner?	1	2	3	4	5
The workshop stimulated my learning?	1	2	3	4	5
The training materials used complemented the presentation?	1	2	3	4	5
The length of time to complete the training was sufficient?	1	2	3	4	5
Participation and interaction were encouraged?	1	2	3	4	5
The Instructor was helpful and engaging?	1	2	3	4	5
I gained valuable skills that I can apply to my work setting?	1	2	3	4	5
The presenter was knowledgeable and answered questions satisfactorily?	1	2	3	4	5
The most valuable aspect of this workshop was:					
The least valuable aspect of this workshop was:					
Additional Comments:					
Name (Optional): Role:					
Training Program: 1/2-Day 1-Day 2-Day					
Years of service: <1 Year 1-5 Years 5-10 Years 10-20 Years >20 Years					
Have you taken previous Crisis Intervention Training? YES NO					
Which program? MOAB NVCI UMAB PMAB Other:					
Thank you!					

Safe Management Group
Caring for your safety

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