TITLE
Safety Sitter Role

AUDIENCE
Sitters, PCTS

DESCRIPTION
Discuss expected behaviors & responsibilities for sitters of patients with suicidal ideations (SI) and potentially aggressive behaviors. Differentiate between patient safety and caregiver safety, and the importance of both. Discuss appropriate communication and other interventions for mental health crisis behaviors.

Requirements

Due Date
Jun 30, 2019

Overview
To provide education on safety for Sitters of patients identified to be at risk for suicide , aggression or other behavioral health conditions.

Performance Goal
Discuss expected behaviors & responsibilities for sitters of patients with suicidal ideations (SI) and potentially aggressive behaviors. Differentiate between patient safety and caregiver safety, and the importance of both. Discuss appropriate communication and other interventions for mental health crisis behaviors.

Audience
Sitters and PCTs

Subject Matter Experts
Catherine Dunham, M.A., LPC (Program Director for Behavioral Health Patient Safety and Quality)

Sponsor
Sheri Winsper

Department/Group

Central Staffing Office, System Services Quality and Patient Safety

Vision 2026 Strategy

Exceptional Care

How does this training align with HRO?

Reaching Zero Harm , I will expect the unexpected and mitigate the risk before it happens.

SECTION 1

High Reliable Organization

After this Lesson, you will be able to
use Error Prevention Tools, in daily activities, to reduce errors and keep Texas Health a high reliable organization.

Topic 1: Error Prevention Tools

SECTION 2

Sitter Scope and Role

After this Lesson, you will be able to:

- **summarize** the role of a sitter.
- **differentiate** the types of patients that need a sitter.

Topic 1: Who Can be a Sitter?

Topic 2: Role of the Sitter

Topic 3: Types of Patients Who May Need a Sitter

Topic 4: Patient vs. Caregiver Safety

SECTION 3

Patient Safety

After this Lesson, you will be able to:

- **provide** examples of how they can prevent harm to patients.
- **summarize** Their role in keeping patients at risk for suicide safe.
- **differentiate** between role expectations based on the patient's risks.
- **recall** How to call a code blue or RRT.

Topic 1: Why are Patient Safety Sitters Needed?

Topic 2: When do we use Sitters?

Topic 3: Role in Patient Care

Topic 4: Policies: Risk for Harm Patients

Topic 5: Falls Prevention and Documentation

Topic 6: Risk For Suicide

Topic 7: Specific Rules for Patients at Risk For Suicide

Topic 8: Special Circumstances with 1:1 observation

Topic 9: Code Blue/Rapid Response

SECTION 4

Caregiver Safety

After this Lesson, you will be able to:

SECTION 5

references

No learning objective specified

- **recognize** the beginning stages of escalating behavior.
- **provide** examples of when violent behavior is most likely to occur.
- **summarize** ways they can avoid and respond to violent behaviors.
- **differentiate** between therapeutic and non-therapeutic communication.

Topic 1: Patient violence/ behaviors

Topic 2: When Violence is Most Likely to Occur

Topic 3: How to Avoid and Respond to Violent Behaviors

Topic 4: Communication: Process for Sending and Receiving Messages

Topic 1: References

SECTION 1

High Reliable Organization

Page 1 of 1 – Error Prevention Tools

Before this module begins, please click on the document below to review the Error Prevention Tools, used at Texas Health as part of the organization's journey to become a high reliability organization. Should you want to refer back to the document later, it can be found by searching on MyTexasHealth.

FILE TYPE	URL	TITLE
PDF	https://cdn.fs.app.getsynapse.com/mhIH5KzGRFgETIyTAb5Q?policy=eyJleHBpcnkiOjE3MDYxNDA4MDAsImNhbGwiOlsicGljayIsInJlYWQiLCJ3cml0ZSIsInN0b3JlIl19&signature=2613fedac0f3dc37cbac2e84943a93dd83d1c0efc3aa98e0ab3bb51721bbbe2f	Error Prevention Tools.pdf

SECTION 2

Sitter Scope and Role

Page 1 of 4 – Who Can be a Sitter?

•Unlicensed clinical staff working as a Patient Care Tech or Certified Nursing Assistants that have completed this module.

•Texas Health Employee or contracted sitter through Central Staffing Office

• An available Texas Health Employee or clinical staff able to provide observation.

•It is also highly recommended to complete a Crisis Prevention Intervention Course (CPI)

Page 2 of 4 – Role of the Sitter

•Patient Care Technicians/Assistants provide care for the patient, and maintain continuous visual contact with the patient.

•They provide all PCT type cares for the patient in addition to the observation part of the role (i.e. bathing, feeding, toileting, etc.)

• They assist RN with completing "Safety Precautions Checklist" and maintaining safety of patients identified as being at high risk of suicide

•While assigned to the patient as a sitter, **the Registered Nurse (RN)** maintains accountability for the patient and the sitter.

Page 3 of 4 – Types of Patients Who May Need a Sitter

•Patients with known suicidal thoughts/plan

• Patients who are at high risk for assault and aggressive behaviors

•Impulsive patients (Traumatic Brain Injury)

•Patients with behavioral disorders: Schizophrenia, Psychotic Disorders, Mood Disorders like Depression, Anxiety or Bipolar disorder

---

Page 4 of 4 – Patient vs. Caregiver Safety

•Suicidal patients need protection from themselves (also called a patient safety sitter).

- Other behavioral disorders can place the caregiver at risk for harm from the patient (caregiver safety sitter).
- Each of these will be discussed in the following sections.

Assessments

Question 1

What is in the scope of practice of a sitter?

- [ ] Complete medical assessments
- [x] Provide continuous observation
- [x] Assist the patient with hygiene and feeding

Question 2

What type of Patient conditions might require a sitter?

- [x] A patient has been identified to be at a high risk of suicide.
- [x] A patient who is impulsive and not easily redirected.
- [ ] A patient who has the flu.
- [x] A patient who is experiencing hallucinations and agitation

SECTION 3

Patient Safety

Page 1 of 9 – Why are Patient Safety Sitters Needed?

- **Patient's may try to harm themselves due to several conditions:**

–Desire to kill themselves (suicidal ideation or SI patients)

–Severe dementia or delirium

–Altered thoughts due to traumatic brain injury

- Potential for aggression due to substance use, withdrawing from alcohol or other substances or due to experiencing psychotic symptoms (delusional thoughts, hearing or seeing things that others do not)

Page 2 of 9 – When do we use Sitters?

•For patients that require continuous close observation (possible suicide risk)

•Patient is confused and is at risk for causing harm to oneself

•Impulsive patients, those that can not follow instructions, and are at risk for falls

---

Page 3 of 9 – Role in Patient Care

•Maintain visual contact with patient at all times

•Notify the nurse or supervisor of changes in patient condition or immediate care needs outside the scope of the sitter/PCT

•For suicidal patients/or those at risk for self harm: be within arms reach of the patient for sudden impulses of patient. If the room layout does not allow for sitter to be within arms reach then the sitter should be physically close enough to intervene if needed.

•Call an RRT or Code Blue when appropriate

Page 4 of 9 – Policies: Risk for Harm Patients

•Fall Precautions

–Reliable Care Blueprinting for Falls

•Restraints Policy

•System Suicide Risk Assessment Policy

•System Sitter Policy

•RRT/Code Blue

•Standardized Plain Language Emergency Codes

Page 5 of 9 – Falls Prevention and Documentation

•Fall risk patient is identified by a sign outside the room with 1, 2, or 3 stars (more stars, the higher risk the patient is for falling)

•Patient should have a yellow arm band on

•Utilize non-skid slippers, and yellow gown if available

•Keep bed in low position and bed alarm on

•Assist patient to bathroom and keep in visual sight while toileting.

•Educate patient the need to use assistance to prevent falls

•The RN has primary documentation responsibility for assessing risks for falls.

•The Sitter/PCT can add interventions in place as mentioned previously

•Keep in mind some medications the patient are on for depression that occurs with suicidal ideation can cause unsteady gait, & forgetfulness of use of safety devices.

Page 6 of 9 – Risk For Suicide

Common Methods Used to Attempt Suicide in the Hospital Setting:

- **Hanging**: Bed sheets, bell cords, bandages, Kerlex, restraint belts, Plastic Bags, Elastic Tubing, Oxygen tubing, Clothing items
- **Cutting**: Razor blades, needles, sharp objects
- **Strangulation:** Linen, wires, long cords, clothing (especially items with long ties, shoe laces, belts, long pant/shirt sleeves, elastic
- **Overdose:** Medications in belongings or that the patient has been hoarding, chemicals (example: cleaning solutions on the housekeeping cart)

As soon as a patient is identified to be at risk for suicide the RN and the Sitter/PCT will assess and remove objects from the patient room that could be used by a patient to harm themselves.

- The Suicide Precautions Checklist was developed by THR to help staff verify safety measures have been implemented.
- The Checklist should be completed: **BEFORE PATIENT ENTERS ROOM, AT EACH SHIFT AND ANYTIME A VISITOR LEAVE.**

•Some examples of things the Sitter and RN should work to remove and why they could be dangerous: This is not an all inclusive list

Common Items	Potential Hazard
Plastic Bags, Plastic trash can liners	Can be used as an asphyxiation/ suffocation device
Sheets, Pillow Cases, extra linen	Can be used a ligature or as an asphyxiation/ suffocation device
Strings, Cords, Rope, laces, Call Lights, IV Tubing(i.e. Phone Cords, electrical cords, Window Blind Cords, Nurse Call Lights)	Can be used as a choking device , as an asphyxiation/ suffocation device or as a weapon

Needles, glass products, pens, pencils, Sharps	Can be used to self-harm or as a weapon
Unnecessary Medical Equipment	Can be used as an anchor point and devices plugged into outlets can be used for self-harm or as a weapon
Remote Controls	Can be used to self-harm by swallowing batteries or as weapon
Toiletry / hygiene Items not being used	Items like **shampoo, mouth wash, hand-sanitizer** contain potentially poisonous chemicals that are not intended to be ingested or contain alcohol. Items like a **toothbrush** could be swallowed or sharpened to be used to self-harm or as a weapon. A common item like a **tampon** can be swallowed and used as an asphyxiation/ suffocation device.

FILE TYPE	URL	TITLE
WORD	https://cdn.fs.app.getsynapse.com/aDrpE5wZTmLcIY4prTbE?policy=eyJleHBpcnkiOjE3MDYxNDA4MDAsImNhbGwiOlsicGljayIsInJlYWQiLCJ3cml0ZSIsInN0b3JlIl19&signature=2613fedac0f3dc37cbac2e84943a93dd83d1c0efc3aa98e0ab3bb51721bbbe2f	Revised sitter suicide checklist.docx

- **Plastic utensils only**, and paper plates and cups should be brought into the patient's room.

- All Plastic utensils, paper plates and cups should be immediately removed from the patient room after meal time.
- **Cross Check** that all dietary items are accounted for by : Counting the items brought into the room, and count when they leave the room.
- Aluminum Soda Cans should not be brought into the room - aluminum can be used to self-harm.

- Monitor that housekeeping carts are not left unattended
- Keep a close eye for lose items left out on the cart like cleaning liquid, plastic bags etc that can be grabbed by the patient when staff turns their back.
- Make sure unneeded linens, plastic trash can liners that were removed from the room are NOT brought back in to the room.

- Make sure patient is in hospital approved scrubs

• Do not leave medications brought from home or patient belonging bags in the room with the patient.

•Check belongings of those entering room, and ensure that items on the removal list do not remain in the room.

Remember: IT ONLY TAKES A FEW SECONDS FOR A PATIENT TO GRAB MEDICATIONS AND OVERDOSE.

.

Page 7 of 9 – Specific Rules for Patients at Risk For Suicide

•One of the most Important Life Saving Interventions we can provide patient's at risk for suicide is continuous observation:

- Since we can not remove every hazard from the environment we need to watch closely. By continuously observing the patient we are able to intervene if a patient attempts to self-harm or act on their suicidal thoughts.
- That is why the sitter/PCT **must be within arms reach or close enough to IMMEDIATELY intervene** if the patient attempts to harm self.

•A patient must remain on 1:1 observation until the Physician has discontinued the patient from needing a 1:1 sitter. While a patient is on 1:1 observation there should be NO time a patient is left alone:

That means.....

- The family **cannot** be the sitter for the patient, even for bathroom breaks; and should not be left alone with the patient.

•Sitter may not leave the room without a hospital staff person as relief.

•If the patient goes off the floor for a test/procedure, the sitter goes with the patient.

It is important that as a Sitter you are focused on the patient :

- Sitter can not have reading materials, phone calls/texting, computer use (other than charting)
- Do not sit outside the patient's room with back facing the patient
- Do not let your guard down and think you can trust the patient. For example, letting a patient at risk for suicide use the bathroom with out being supervised or be left alone for a few minutes because the patient promises they won't do anything.
- **If you start to feel sleepy:**

- Stand up, stretch and walk around the room to keep alert
- Ask the nurse for relief so you can take a break
- Ask for another staff to bring you coffee/ cold water etc

- Notify the RN or charge of any acute change in behavior or sudden verbalization or talk about current plans for carrying out suicide.(Will discuss more)
- Be therapeutic in conversation, but don't discuss personal views on suicide .(Will discuss more)

These signs include common High-risk indicators for Suicide and can signal the patient may be at IMMINENT RISK:

- Increase Anxiety/ Panic
- Dramatic Mood Swings
- Tearful/ crying spells
- Irritability/ Agitation
- Abrupt improvement in symptoms or emotional state (example: suddenly cheerful or high energy level)
- Chronic or unbearable pain
- Feeling Hopeless or trapped
- Refusing visitors, medications, food
- Increased use of bathroom/ making excuses to spend time in bathroom area
- Trying to gain access to means to harm self: extra linens, medication, items in their belongings
- Anger with being monitored closely
- Requesting to discharge early or leave AMA
- Making comments about wanting to die, threatening to kill/hurt themselves.

- **Take all threats of suicide/ self-harm seriously and avoid making assumptions about the motives behind suicidal statements (example: "they just want attention"**)
- Do not talk about your personal beliefs about suicide-
- Patients experiencing mental illness or suicidal thoughts often already experience shame and stigma. Discussing your personal beliefs about suicide or mental illness contributes to a patient's feelings of shame, being a burden to others or feeling hopeless.
- Let the patient know that their safety is important to you and that you need to let the RN know about their sucidal thoughts

Observation Documentation

Patient who are on Suicide Precautions require documentation of the patient's general activity, and the initials of the staff observing the patient, every 15 minutes.

This is done on the paper Flow sheet

FILE TYPE	URL	TITLE
PDF	https://cdn.fs.app.getsynapse.com/1HD5aYzmRGaY6lnb4oKz?policy=eyJleHBpcnkiOjE3MDYxNDA4MDAsImNhbGwiOlsicGljayIsInJlYWQiLCJ3cml0ZSIsInN0b3JlIl19&signature=2613fedac0f3dc37cbac2e84943a93dd83d1c0efc3aa98e0ab3bb51721bbbe2f	Downtime form Round sheet.pdf

Page 8 of 9 – Special Circumstances with 1:1 observation

In the event the hospital experiences a surge in patients identified to be at a high risk for suicide, particularly in the Emergency Department, the following is to occur:

- administrative supervisor should be contacted for assistance.
- Alternative suicide risk mitigation strategies **should be employed until the resources are available to supply 1:1 sitters.**
- Examples of alternative strategies include, but are not limited to,
  - placing suicidal patients in close proximity to allow assigned staff to maintain line of sight observation.

Page 9 of 9 – Code Blue/Rapid Response

•If patient condition declines, or makes an attempt to harm themselves and RN is not immediately available, an RRT should be called at ext. 9999

•If a patient were to stop breathing or have no pulse:

–Yell for help

–Call a Code Blue – ext. 9999

Start CPR

Assessments

Question 1

When are patient safety sitters needed?

- [ ] When the nurse needs help completing assessments
- [ ] When a patient is a low fall risk
- [x] When a patient is identified as being at risk for suicide
- [x] When a patient is impulsive and has trouble following directions

Question 2

Select the answer (s) that does not describe the role of a safety sitter.

- ○ To notify the nurse when there is a change in the patient's condition.
- ● To periodically watch a suicidal patient when they are a wake.
- ○ To call an RRT or code blue when appropriate
- ○ To assist the nurse with making the patient's room safe before the patient enters the room.

Question 3

To call a RRT or Code Blue dial...

- ○ 911
- ○ 9955
- ○ 8888
- ◯ 9999

Question 4

When is the suicide precautions checklist completed by RN and Sitter

- ○ Every 15 minutes
- ○ Once a shift
- ○ Before the patient enters the room, each shift and at discharge
- ◯ Before the patient enters the room, each shift and after a visitor leaves

SECTION 4

Caregiver Safety

Page 1 of 4 – Patient violence/ behaviors

In the Emergency department patients with the potential for aggressive behaviors often present to the hospital under the influence of alcohol or substances or experiencing psychotic symptoms like visual or auditory hallucinations.

Some other common behaviors of potentially aggressive patients include:

- **Verbal aggression**
- Attempts to elope
- refusing to eat or drink
- Self-harming behaviors
- or making aggressive gestures to objects or people

- Patient violence against staff is a serious occupational hazard.
- It can occur in any unit, the likelihood is higher in **ER, ICU, Trauma, and Psychiatry**.

- Violence against nurses, sitters and PCTs, by patients and family members, is on the rise.
- To decrease violence against nurses sitters and PCTs, the Crisis Development Model principles are being borrowed from the Crisis Prevention Training (CPI).

Crisis Behavior Level	Staff Attitudes/Approaches
Anxiety – change in behavior	Supportive (an empathetic and nonjudgmental approach)
Defensive- beginning to lose rationality	Directive (calming down an escalating behavior)
Risk behavior- behaviors that may present a risk to self/others	Physical intervention (managing risk behaviors through skills learned)
Tension reduction- decrease in physical and emotional energy	Therapeutic rapport (re-establish communication)

Anxiety is a subjective feeling that a person experiences in response to stress and results in a change of behavior.

See Below for some common symptoms of anxiety

Pacing	Constipation/diarrhea	Shaking
Elevated blood pressure/pulse	Sweating	Trouble breathing
Nausea	Difficulties with sleep	Headache
Restlessness	Dizziness	Frequency of urine

How do you recognize change in this patient's behavior? As a sitter or PCT what would you do?

- You can ask the patient, "I see that you are pacing and restless. Is there anything I can help you with?" If patient is willing to talk about it you can sit down with the patient, show support by empathetically listen to their concerns. By doing this you will build rapport, gain patient trust and will provide help if needed.

If the patient is not willing to talk, you can always report to the nurse your observation that the patients is reporting anxiety or seems anxious.

MEDIA SERVICE
YouTube

URL
https://youtu.be/pBe4A32fpyI

TITLE
De escalation Techniques

- Early Identification of Escalating Behaviors and early intervention can prevent violence and the need to use restrictive interventions like restraints:
- Recognize signs of anxiety
- Be aware of situations that can trigger the patient to become frustrated or anxious

---

Page 2 of 4 – When Violence is Most Likely to Occur

When is violence most likely to occur? Listed below are common times for violence to occur and examples of what could occur or why these times during treatment can precipitate violent behavior.

•Meal times- they do not receive the correct food, they want a second helping and are denied

•During visiting hours- Either an anticipated visitor does not visit, the patient has a conflict with their visitor or receives upsetting news during the visitation

•Patient transportation- anxiety about what will happen at the location they are being transferred too, use the transition time as an opportunity to try to elope if they are involuntary.

•When service is denied- Not feeling heard or feeling like their needs are not being met.

•When a patient is involuntarily admitted- Might cause the patient to feel trapped due to the fact they do not believe they need help

•When a health care worker attempts to set limits on eating, drinking, or tobacco or alcohol use- Being told "NO" can be frustrating especially when the patient might be experiencing cravings for nicotine/ alcohol or withdrawal symptoms.

•Disruption of sleep- Not having enough sleep will make any one feel on edge. If a patient already has a tendency to have low frustration tolerance, not having enough sleep will only narrow their ability to tolerate frustrating situations.

• Experiencing pain- Having untreated pain is another situation that can lead to feeling frustrated.

Each of the above represent common triggering situations during treatment that have the potential for the patient to become frustrated or experience increased anxiety.

Page 3 of 4 – How to Avoid and Respond to Violent Behaviors

1. Avoid using medical jargon, instead provide information to the patient using terms they understand
2. Use non-threatening body language when approaching a patient
3. Approach the patient with respect and being supportive of their issues or problems
4. Be responsive when a patient expresses a problem
5. Be clear when setting a limit (Ex: It seems like you're upset but I need you to lower your voice and not yell so I can better understand what you are needing).
6. Minimizing lighting, noise and loud conversations: Too much stimulation can increase anxiety and agitation

These tips will be discussed more throughout the training

Laying the groundwork for positive patient relationships can help avoid violence. This can be achieved by doing a few simple things:

•Call the patient by name they prefer

•Make eye contact

•Pause to connect with the patient

•Make small talk

•Listen to requests, concerns, fears

•Accommodate patient needs to extent possible

Maintain behavior that helps diffuse anger:

- Present a calm, caring attitude
- Use non-confrontational language
- Avoid any behavior that may be interpreted as aggressive
- Maintain professionalism
- Remain customer service focused

Some tips to keep in mind:

- When a patient is feeling scared, anxious or frustrated they may say things that can be offensive or hurtful. Try your best not to take what is being said personally and remember their words are a product of their emotional state.
- Be aware of your own emotional state. If you start feel yourself becoming upset or frustrated with the patient let the nurse or charge nurse know you need to take a break and step away from the situation.
- **Avoid confrontational language.** Confrontational language in critical conversations blocks each party from listening to the others' interest and needs. confrontational language typically uses absolutes like **"always" and "never".** For example, "We always do it this way", "You never listen"

Encouraging/assisting patient with physical needs:

- Providing quiet environment for patient to sleep or take rest
- Encouraging adequate nutrition
- Assist patient with ADLs
- Physical movement
- Providing appropriate comfort measures

By helping meet the patients basic helps the patient feel safe and builds trust with staff.

Here are some basic ways staff can achieve this:

Providing quiet environment:

For example, dim lights, make sure call bell in place, noise-free environment- less noise, talk in quiet volume

Encouraging adequate nutrition:

Assist with meal time and completing menus. During meal times make sure patients eat and drink. Inadequate dietary intake can lead to change in behavior.

ADLs:

Assist patient with ADLs and bath.

- Supervise as needed.

- Provide supplies such as towel, soap, etc.
- Assist with toileting.

Physical movement:

- Assist and supervise
- Assist patient with ambulation, firm, steady gait or confused to prevent falls

Comfort measures:

- Ask if patient is in pain
- Ask for preferences of TV channel

Page 4 of 4 – Communication: Process for Sending and Receiving Messages

•According to Edward Hall, an anthropologist we relay message:

–**Nonverbal: 65%**

–**Verbal: 35%**

Examples of Verbal communication:

•People speaking to each other over telephone

•Shouting across a field/room

•Mumbling or humming

•General conversation

Examples of Non-Verbal communication:

- Body language - how you hold and move your body
- Personal space - distance between individuals
- Communication through touch - for elderly patients, therapeutically holding patient's hand or patting their shoulder

Building a therapeutic relationship with patients requires:

rapport

trust

respect

genuineness

empathy

Nonverbal behaviors to be aware of:

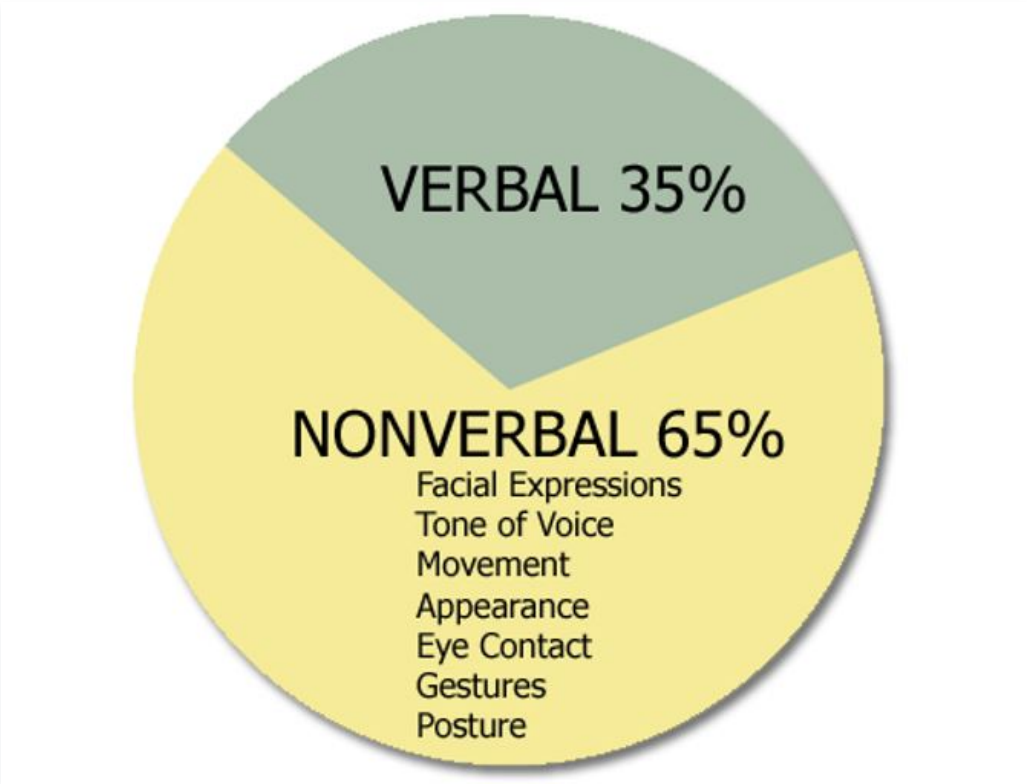
placing hands in pocket

rolling eyes

pointing

facial expressions

crossing hands



Non-Verbal Cues we Send

•Body Language: how you hold and move your body. The patient can read your body movements and posture. For example, rolling your eyes, placing hands in pocket, shaking your head, etc. Staff should be aware of their body language. The way they stand and of their facial expressions.

•Personal space

•Communication through touch

•Supportive Stance: The supportive stance is where a persons arms are open and body is slightly turned. This communicates nonthreatening respect and safety.

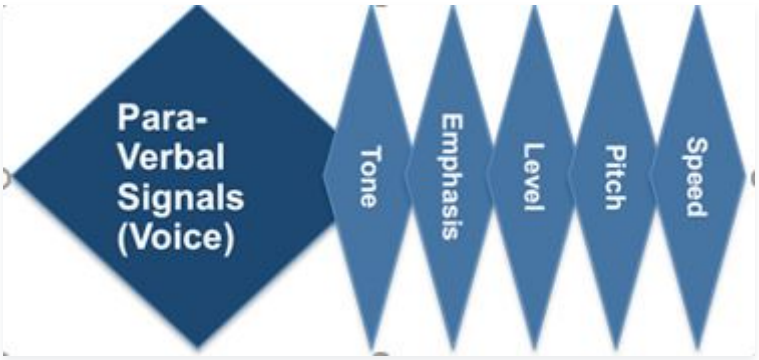
Be aware of the use of touch and the importance of asking permission to touch.

- Based on culture, gender or past traumatic experiences touching can potentially be a trigger for a patient and could cause escalating behaviors.

Paraverbal Communication:

•Watch tone and volume when speaking to patients to prevent the situation from escalating.

• Patients experiencing psychosis or have past trauma can be particularly sensitive and easily overwhelmed by loud or aggressive communication.



Non-therapeutic Verbal Communication :

•Giving orders

•Making demands

•Matching threats

•Speaking in anger

•Making unreasonable rules

•Acting upon impulsive decisions

Telling the patient what you feel

Checklist for good verbal communication:

- Making eye contact while communicating is important because it shows you are listening
- Swearing and shouting can be intimidating
- Do not chew gum while having a conversation
- Do not text while speaking to someone or use phone
- Always try to speak clearly and use words everyone can understand
- Make positive facial expressions
- Listen to the person you are speaking to
- Have a relaxed body language
- Do not speak over other people

Keep to the point when explaining something

Therapeutic Communication Techniques

- Acknowledge and validate patient's feeling and reassure them
- Listen attentively, provide support, and gain patient trust
- Sometimes showing TLC can calm the situation. Build rapport with patient.
- Staff should be mindful of their verbal and nonverbal communication.

Verbal	Non-Verbal
Silence - allows other to lead conversation	Be aware of your own nonverbal behavior
Accepting - positively accepting patient's needs in a nonjudgmental manner	Observe an open posture
Giving recognition - acknowledging and recognizing patient needs	Establish eye contact
Offering self – being available for patient	Relax
Restating – ensures whether an expressed statement is understood or not	

Verbal De-escalation techniques:

•**Do not be defensive** even if comments, curses, or insults are directed at you. They are not about you.

•**Be honest**. Do not make promises you are not able to follow through with.

•**Be respectful** when firmly setting limits or calling for help. The agitated individual is very sensitive to feeling shamed and disrespected. Always think safety first.

•**Empathize** with feelings but not with behavior.

Suggest alternative behaviors where appropriate

Trust your Instincts:

If de-escalation is not working, **STOP!**

If situation feels unsafe, **LEAVE / CALL FOR HELP!**

5 De-escalation Don'ts: T.A.C.O.S.

T: THREATEN

A: ARGUE

C:CHALLENGE

O: ORDER

S: SHAME

MEDIA SERVICE
YouTube

URL
https://www.youtube.com/watch?v=6B9Kqg6jFeI

TITLE
Understanding Agitation: De-escalation

Assessments

Question 1

Reflect back on the video on anxiety. Select the answer(s) below that represent how staff were able to successfully respond to a patient's anxiety.

- [ ] Showed the patient that they are in charge.
- [x] Listening to the patient's concerns and understanding where they are coming from
- [x] Taking the time to get to the patient
- [ ] Giving the patient a comforting hug.
- [x] Proving the patient frequent updates and open communication

Question 2

Select the symptom (s) below you might notice if a patient was feeling anxious

- [x] Pacing in the room or down the hall
- [x] mumbling or talking under their breath
- [x] tapping their foot repeatedly on the floor
- [ ] Low blood pressure and high pulse
- [x] Frequently complaining about having a headache and/or stomach ache
- [ ] Talking in slow soft voice

Question 3

True or False The following situation is an example of a common time in treatment when a patient might become violent: A patient presents to the ED complaining of back pain. After the patient is seen by the doctor they are informed that they pain medication they are requesting is being denied and that the doctor recommends they try to address their pain with over the counter pain medication.

- (x) True
- ( ) False

Question 4

Select the answer (s) below that represent therapeutic communication techniques:

- [x] Remaining silent and allowing the patient to talk
- [ ] Telling the patient about how you feel
- [x] Repeating back to the patient what you heard them say to make sure you understood
- [ ] Talking over the patient
- [ ] having eye contact with the patient and rolling your eyes while they talk
- [x] Letting a patient know that you can understand how the current situation is causing them frustration.

Question 5

Select the answer (s) below that is not one of the 5 De-escalation Don'ts (T.A.C.O.S)

- [ ] Shame
- [x] Collaborate
- [ ] Threaten
- [x] Alternatives
- [ ] Order

SECTION 5

references

Page 1 of 1 – References

•Crisis Prevention Institute. (2015). Participant workbook. Milwaukee, WI: Crisis Prevention Institute.

•Drew Guest: Blitz Martial Arts Australian Magazine. (2008). Retrieved from http://www.blitzmag.net/self-defence/199-de-escalation-victory-without-violence

•Kim, S., Ideker, K., & Todicheeney-Mannes, D. (2012). Usefulness of aggressive behaviour risk assessment tool for prospectively identifying violent patients in medical and surgical units. Journal Of Advanced Nursing, 68(2), 349-357.

•Punjani, n. S., & Bhanji, s. M. (2013). Role of therapeutic communication in dealing with aggressive patients. Journal On Nursing, 3(4), 29.

•Springhouse review for psychiatric and mental health nursing certification. (2002). (3rd ed.). Ambler, PA: Lippincott Williams & Wilkins.

•Texas Health Resources. (2015). About Texas Health Resources. Retrieved from https://www.texashealth.org/Pages/About-Texas-Health-Resources.aspx

•Transcendental mediation. (n.d.). Brain landing page. Retrieved from http://tm-ireland.org/brain-landing-page/

•https://youtu.be/pBe4A32fpyI?t=2m54s

•(The American Society for Health Care Engineering of the American Hospital Association , 2018)

- The Joint Commission Sentinel Event Alert Issue 56 Detecting and treating suicide ideation in all settings
- Emerg Med J. 2012 May;29(5):399-403. doi: 10.1136/emj.2010.105239. Epub 2011 Apr 13.
- Gen Hosp Psychiatry. 2013 Sep-Oct;35(5):528 36. doi: 10.1016/j.genhosppsych.2013.03.021. Epub 2013 May 20.
- Jointcommission.orgURL:https://www.jointcommission.org/dateline_tjc/de-escalate_aggression_and_potential_violence_/

Assessments