PHOENIX TRAINING GROUP

GUIDELINES TO HELP ENSURE A SAFE AND THERAPEUTIC RESOLUTION WHEN CONFRONTED WITH A POSSIBLE PHYSICAL INTERVENTION

1. **TEAMWORK** is essential and one of the most important elements in creating a safe, effective and therapeutic environment for the client as well as the staff. If the staff does not, or will not work as a team, or for any reason appears not to be in control of the situation, the clients or the unit itself, then the clients will pick up on this breakdown and act out on that lack of stability, consistency and control that they need within the hospital setting, to feel safe and cared for.

2. The clients need the presence of limits, consistency and control from the staff team within the unit setting. When faced with the lack of those limits, consistency and control from staff, clients will usually act out verbally, physically or emotionally as a way to try to obtain that control and security for themselves and not always possessing the verbal skills to voice their concerns, they will act out to make their fears known in the only way they are familiar with. Although the client may not always be aware of their therapeutic needs, they may feel inside that they are not in control and want desperately for someone within the hospital setting to take the control for them so they may feel safe. This is where the team approach can best serve the clients while at the same time producing feelings of cohesiveness and support among the staff.

3. Along with teamwork, **COMMUNICATION** is equally important when either entering into a possible assaultive situation, or laying groundwork ahead of time, in order to prevent possible assaultive situations. Make sure **EVERYONE** (including licensed as well as clinical staff) is aware of any possibilities and concerns you might have, as well as any behaviors exhibited by the clients you feel may be important. Also, **NEVER** make a decision regarding the client's direct care (or communicate any decision to the client) without first checking with the licensed staff or supervisory personnel in charge of that unit. Operating as a team will serve to defuse many assaultive situations, or prevent them from becoming a possible assaultive situation in the first place while helping to ensure a sense of stability and cohesiveness among the staff.

4. If time allows, make a definite **PLAN OF ACTION** when faced with a possible assaultive situation, designating who will be the "Leader" or in charge, along with who else does what, when and how, in the case that it requires physical intervention. Try to determine what the trigger, or initial issue that is causing the client to escalate. This will help during the de-escalation process, communicating to the client that you care enough to try to solve, or at least address the issue first. Also, try to decide how long the verbal intervention will go on from the person in charge of the situation, so that the process does not drag out and the client eventually gains the control of the situation. All of these suggestions will lessen the chance of the situation becoming out of control and help prevent injuries to the client as well as to the staff. It will also send the message to the client that the staff are organized, in control and able to provide the care and safety that they require during a difficult time.

5. If there is no time to formulate a plan of action, then be aware of either too many staff taking charge of the situation, or none at all. Don't be afraid to take charge yourself, or delegate someone else if you don't feel you have the skills or experience. If you are uncertain of who is in charge of the situation, don't hesitate to ask among the staff present, but remember to keep the questions regarding the clients among the staff, out of the earshot of the clients, as they might feel the staff are not handling the situation well, or act to further escalate the client with excessive interactions among staff. Also, consider the staff member's experience, abilities, strengths and weaknesses before delegating their tasks or responsibilities.

6. If possible, take time to think if the potentially assaultive client has any specific issues with any one staff member. And if so, then consider having that staff member not being involved in the verbal intervention as it might further escalate the process, but have them ready in the wake of a physical intervention. Try not to set up a button-pushing situation on either side or a power struggle situation.

7. If possible, take time to think if the potentially assaultive client has a good rapport with any one staff member within an appropriate and therapeutic type boundary situation. If there is no chance of the situation becoming one where the client creates a splitting relationship among staff and client, then consider having that staff member attend the situation in an attempt to de-escalate the client. Don't allow egos to get in the way of a potentially assaultive encounter becoming a de-escalated one. At the same time, make sure to avoid power struggles and manipulations by the clients always threatening to become assaultive unless they are allowed to speak to a select staff member.

8. Once a leader has been established or delegated, then everyone involved must stay with and follow the directions from that leader throughout the situation. Never dispute the decisions of the leader aloud, unless the leader is presenting an element of gross negligence, very bad judgment or danger to the client or staff. Issues involving staff should never be discussed during the situation. Always talk about them afterward in private in order to better create a better team.

9. Set strong but reasonable boundaries with the clients. Don't allow for the control to travel back and forth between client and staff, but at the same time, allow the client the opportunity to gain control of him or herself in the beginning stages of the situation. The client should have the chance of making the initial decision of walking to a designated location or being physically escorted, unless the client has already been deemed a danger to self or others, or is threatening violence. However, the time allowed for the client to make their decision needs to be fairly short and concise as the client may not have the ability to make such decisions for themselves. If the client continues to refuse to walk, comply with requests and direction, or becomes verbally or physically threatening, then the client loses the opportunity to walk themselves without assistance. Staff will then escort the client, whether physically assisted or not, all the way to the designated location, even if the client then agrees to walk cooperatively. Never go back and forth with your, or the team's decisions once they are made and communicated to the client.

10. If the client attempts to struggle while being escorted, continue to hold the client firmly while walking. If the client becomes combative or strikes out at staff, then staff may subdue the client to the floor for his or her protection and staff's. At this point, the client has given up the right to walk or be escorted and will now be carried or transported to the designated location. The client **SHOULD NOT** be allowed to get back up and walk themselves after this point once staff has made the decision to physically subdue or restrain the client. At this time, physical restraints should be applied to the client's arms and legs for their safety as well as for staff's. Also, it will be the decision of the leader at this point whether the client can be carried or needs to be transported by gurney.

11. When faced with a possible assaultive situation from a client, and you have the time to make a plan of action, always try to plan for a **SHOW OF FORCE** when assembling the team to deal with the client. This foresight will usually discourage the client from acting out further within the situation you are involved in, as well as and possible future incidents.

12. If you are alone or have inadequate numbers of staff to back you up while talking to a client who is showing signs of being out of control and not responding to verbal intervention, but is not an immediate danger to him or herself or others, then think about removing yourself from the situation to alert other staff members, so you can make a team decision of what further actions to take. Never deal with a potentially assaultive client alone or with inadequate numbers of staff, even if you only have a suspicion that the client may become even slightly defiant. Don't set yourself up for injuries involving you, other staff, or the client.

13. The importance of staff who are not directly involved with the physical restraint itself should not be minimized and instead be utilized in areas such as monitoring the area where the situation is taking place for the potential for other clients, family or friends becoming agitated, assaultive, fearful and manipulative. Staff not directly involved should also monitor the nursing stations and phones, be available to place restraints on the beds, notify additional staff if needed and clear pathways of clients and visitors. Use your extra staff effectively.

14. Allow for clear, and if possible, pre-planned signals to be given during the incident to prevent mistakes, confusion or overreactions on both sides. Also be aware of and avoid threatening stances or challenging situations between staff and clients. Try never to provoke the assaultive situation by exhibiting threatening posture or comments. Always remain objective, not becoming angry or threatening with the clients. If you do, you're going to be extremely non-effective and will only serve to provoke more confusion, loss of control, anger and injury.

15. Be aware of other clients or visitors possibly being in the area where a situation is taking place and assign a designated staff to direct them away from the area and out of sight of the situation.

16. Have stethoscopes, pens, pencils, jewelry, hair clips and anything you wish to keep safe, or from becoming a weapon against you, away from the situation.

17. Once an assaultive client has been encircled for physical escort, **NO NOT** allow that client to leave the circle. Allowing the client to leave the circle enables him or her to take the control away from the staff and then the control must be regained again, but possible not before the client has escaped or injured him or herself, others or staff, but once staff prevents the client from leaving their room, the seclusion room or forced to go anywhere for their safety or the safety of others, it will then be considered a seclusion and the rules of seclusion then apply to that client.

18. Always anticipate the movements or actions of other staff, as well as the client. Do not be too trusting of either side. This could result in a loss of control and possible injury to both client and staff. Also watch for inadequate holds by staff. Anticipate that the other staff may not have a good hold on the client. This will save you from becoming injured in many cases. And above all while escorting or physically restraining any client…**DON'T LET GO!!!** until the leader gives the okay to do so, or until all of the staff let go at the same time!!

19. Once the client has been placed into the time-out room, whether unlocked, locked or in restraints, he or she may not be allowed to keep personal articles of any kind that might be used as self-destructive items or weapons, such as everything from pockets, belts, shoes, shoestrings, watches, earrings, combs, hair clips, bracelets, necklaces, food, pens, pencils, purses, jackets, reading materials, furniture, etc. Any personal articles removed from the client should be cared for and placed safely away to be returned to the client when he or she is in an appropriate place once again.

20. Allow for the client to spend a designated period of time alone in the time-out room directly following the seclusion or restraint. This is necessary for the client's recovery, whether behaviorally or chemically and the time allotted needs to be decided upon as a team. While the client is in restraints is not a time for verbal interventions as he or she will not be ready to fully listen to the intervention and may become agitated again because of it. The time to talk with a client following a restraint is once he or she has calmed significantly and have returned to the milieu.

21. If possible, when restraining a client to the bed in the seclusion room, the restraint belts should be placed on the bed ahead of time, before he or she is brought in to reduce the time spent setting up, but be careful that the client does not have access to the belts when placed on the bed. Staff should be holding the restraints, ready to apply them when the client reaches the bed.

22. While the client is being restrained, the leader should designate which staff should apply which restraints to the appropriate wrists, ankles and the mid-section, while other staff secures the arms, legs, upper body and head so the staff applying the restraints are kept safe. **DON'T LET GO** until the staff applying the restraints are completely finished and away from the client's reach, whether from combative arms, legs or the client's mouth. If you let go before the other staff are completely finished, there is a good possibility that the staff **WILL GET INJURED** from negligence. Once everyone is finished placing the restraints on the client, go around to each restraint cuff and belt and make sure that they are applied correctly, not too tightly or tightly enough, then make the necessary adjustments with support staff still present to assist you.

23. Never place you keys on the bed or on the floor during the restraint and before leaving the seclusion room, as the client can and will pick them up either in the confusion, or after staff have left the room. Before leaving the room, look around the room to make sure nothing has been left behind that the client could use to escape, harm themselves or injure staff.

24. Staff should always inform the client what is expected of his or her behavior while in seclusion or restraints to give them the opportunity to de-escalate themselves and so they have a clear idea of what they must do, or not do to work themselves out of the restraints or room. Also, if at all possible, give the client a clear time frame of when they can work themselves out of the seclusion or restraints if they are attempting to de-escalate. Don't leave the client guessing of when they might be allowed out, based upon their behavior. They might fear that they could be in the seclusion room, or in the restraints for many hours or all day and this can cause frustration, further escalation and longer time in the room. Seclusion and restraints are meant to be a therapeutic tool and safety measure, not a punishment.

25. When placing the client into restraints, staff must always place that client face up on a designated restraint bed with one arm up above their head and the opposing arm positioned down. Then, following the designated period of time given the patient to calm, begin releasing the patient out of the restraints during one release session. And when doing so, always have backup staff in the room to assist, in case the client becomes assaultive again. **NEVER ENTER THE QUIET ROOM ALONE WHILE CHECKING ON A RESTRAINED CLIENT!** It's advisable to allow the client a short time in the seclusion room with no restraints at all, just to see if the client can maintain a level of control before allowing them to re-enter the milieu once again. All staff (including doctors and clinical staff) **MUST ALWAYS** notify the licensed charge nurse of that unit before removing any restraints or making any changes whatsoever. **THIS IS A MUST!**

26. Any client must be a clear and imminent danger to him or herself, or others before you have the right, or "good cause" to restrain them and the licensed charge nurse for that unit must have a say in that decision. No client may be restrained for simply acting out or displaying a behavior that is not a clear act of assault, self-harm, or endangering others or the environment.

27. There should be no visiting by family, friends, or other clients while a client is in seclusion or restraint and please limit the number of staff who come in to interact with the client as it may serve to escalate or re-escalate and thus lengthen the time spent in the seclusion room.

28. If a female client is being restrained into a seclusion room, then a female staff member must be present while the process is taking place.

29. Clients must be observed at all times while they are in restraints and checked for range of motion. Range of motion involves taking out a limb, one at a time and while holding that limb, staff rotates the limb around, stimulating circulation. Vital signs must also be obtained as soon as possible once the client has been placed into restraints and every hour thereafter while in restraints. Fluids should be offered at least every hour while in restraints, as well as toileting per hour as well. And remember, never enter the seclusion room alone while performing these tasks. During the time that the client is in restraints, they are to be monitored at all times within a 1:1 basis and condition assessment and descriptive documentation needs to be done every 15 minutes.

30. The charting of an incident such as a physical restraint, containment, seclusion or important intervention must be done correctly, as it could mean the difference between a client wrongfully swaying their legal hearing, or having to stay for additional hospitalization. Charting of seclusions and restraints is also a legal document that can be used in court at a later date if the occasion arises and it is your responsibility as a staff to see that it is done right. If you don't feel you can chart effectively, then have someone who is familiar with it help you and if you were not present during the incident, then you may not chart on the incident as if you were. You must get someone who was present during the seclusion or restraint to chart on that client for you. Patient Rights agencies and the courts are not forgiving of bad or insufficient charting of a legal document. All entries must be detailed, true to fact and containing explanations of what interventions took place prior to the incident to demonstrate how the staff began by attempting to de-escalate the client first in an attempt to prevent the incident from occurring at all. You must chart the facts and that we as staff attempted to do everything possible to de-escalate and prevent the seclusion or restraint from happening in the first place.