

EXECUTIVE SUMMARY

Behavior Management Self-Learning Packet for Residents

Behavior management and the use of restraint and seclusion present many complex issues for health care professionals who face these situations on a daily basis. Hennepin County Medical Center (HCMC) has adopted a comprehensive approach to behavior management instead of merely focusing on the use of restraint and seclusion. This approach is consistent with the organization's mission and values and meets accreditation standards and federal regulations related to the use of restraint and seclusion. The new definition of restraint is: "Any manual method used to restrict a person's freedom of movement or normal access to one's body and that he or she can not easily remove." This definition may include methods not previously considered a restraint, such as gerichairs, side rails and medications.

In order for everyone to understand their role in behavior management, self-learning packets, appropriate for the individual's role at HCMC, have been created and are required for employees and providers. Regulatory agencies expected that the health care providers involved in the use of restraint and seclusion, are trained and competent. The changes to these standards are meant to encourage a change in philosophy regarding how restraints are viewed and used. This requires that the use of restraint and seclusion be viewed as a high-risk clinical intervention and employed as a last resort. These changes can be grouped into the following themes:

- Demonstrating an Organizational Philosophy Toward the Use of Restraints
- Promoting and Maintaining Patient Rights
- Involving Clinical Leadership
- Requiring an MD's Order, Evaluation and On-going Reassessment for the Use of Restraints
- Maintaining a Safe Environment for Patients and Staff
- Ensuring Staff Training and Competency
- Understanding and Reducing Restraint Use
- Utilizing the Least Restrictive Device and Promoting Early Release

In response to these changes, HCMC has revised the restraint policy and created medical records forms to facilitate required documentation. It is important to note that restraint use is divided into two pathways with different guidelines: medical/surgical and behavior management, with the behavior management guidelines having the more stringent requirements. Some of the changes that are true for both pathways include:

- 1) Physician orders are required for the use of restraints.
 - No Standing or PRN orders or Protocols.
 - Must use preprinted order form
 - Restraint orders are time limited
- 2) Physicians must see the patient (face to face) and evaluate the need for the restraint use.
 - Behavior management restraint requires this evaluation within one hour of initiation with frequent reassessments.
 - Medical/surgical restraint requires this evaluation within twenty-four hours of initiation with daily reassessments.
- 3) If the ordering MD is not the Treating MD, then the ordering MD must communicate to the Treating MD the need for restraints. This communication must be documented in the medical record.

Prerequisite:

Completion of the self-learning packet entitled “Courtesy and Customer Service for the Health Care Professional” is required prior to the completion of this packet. Many of the techniques used to help with management of behavior are covered in the courtesy packet, which is also enclosed.

Participant Packet and Worksheets

This Behavior Management self-learning packet consists of a:

- **Participant Instructions**
- **On-line Learning Packet**

Objectives

At the end of this self-learning packet, the participant will be able to:

1. Define their role as the TEAM Leader of behavioral management situations.
2. State two strategies for prevention.
3. Identify five warning signs of a potential problem situation.
4. State two medical conditions that affect behavior.
5. State two conditions associated with anxiety.
6. State two behaviors associated with chronic agitation.
7. Explain the importance of assessing a patient at risk for restraint/seclusion use.
8. Identify two personal triggers.
9. Name five active listening skills.
10. State the principles of basic de-escalation skills.
11. Define the five levels of the Escalation Continuum Model.
12. State five alternatives to restraint use.
13. State the two CMS & JCAHO standards for the use of restraints.
14. Identify five signs of distress during restraint use.
15. Define seclusion.
16. Explain why debriefing is important.
17. Explain the role of the TEAM leader in debriefing.

Warning Signs That An Individual Is Becoming Agitated

Attach A

Mild indications of a problem:

- Person is lost and upset. Stops in the hall and is looking around.
- Express their anger appropriately.
- Talking in an excited tone of voice.
- Use gestures that indicate excitement.
- Expresses frustrations and anxiety.
- Making a noise of disgust.
- Talking to self, “Now, where is....”
- Showing frustration due to English as a second language.

Medium indications of a problem:

- Loud voice or yelling, sounding angry
- Use of profanity
- Verbal threats
- Displaying signs of intoxication (stumbling, mumbling, smelling of alcohol)
- Making demands that are not understood. (We should ask ourselves if we could meet the demand of this person and then provide assistance as needed.)
- Aggressive postures such as hands fisted, hands up in the air or invading personal space
- Non-verbal cues such as fidgeting, red face, scowling or glaring
- Expressing irrational thoughts
- Getting out of bed with rails up or other unusual behaviors
- Attempting to get out of a chair with a lap tray in place
- Pulling at IV tubing, naso-gastric tubing
- Inability to engage in conversation
- Throwing items within reach.
- Acting out behavior such as knocking things over or making a scene

Advanced indications of a problem:

- Personal aggression (punching or blocking your path)
- Violent gestures
- Pounding on an object or breaking objects
- Passive-aggressive behavior (alternating timid and confrontational behaviors)
- Refusal to follow directions or orders

- Intimidation that is verbal or non-verbal
- Increased shouting, screaming or use of profanity. (Loud talking and profanity for some doesn't always mean the escalation level as it does for others.)

Examples of Medical Conditions Affecting Behavior.

Condition	Assessment Criteria
Dementia	Agitation, confusion, poor balance
Alzheimer	Agitation, confusion, poor balance
Alcohol Intoxication/Withdrawal	Depression, poor balance, tremors, hallucinations, confusion, agitation, altered reasoning & decision-making skills
Traumatic Brain Injury	Agitation, poor memory, poor motor skills, impulsiveness, poor insight
Nutritional disease	Depends on condition
Diabetes	Anxiety, agitation, confusion
Infection	Anxiety, agitation, confusion
Hearing deficits	Agitation, confusion, isolation
Vision deficits	Agitation, confusion, poor balance
Certain medications	Sleepiness, poor coordination, poor balance
Neoplastic disease	Depends on site affected
Arterial (cerebrovascular disease)	Confusion, poor balance, memory problems
Convulsive Disorders	Disorientation, confusion
Low IQ	Limits ability to respond or understand, poor decision-making skills
Severe Psychological Stress	Depression, could limit ability to respond or understand, poor memory

Organic Conditions Associated with Anxiety

Attach B

Condition	Assessment Criteria
Pulmonary <ul style="list-style-type: none"> • Pulmonary Embolism • Pneumonia • COPD 	Can lead to feelings of shortness of breath and exhibit this as anxiety/agitation.
Cardiovascular <ul style="list-style-type: none"> • Myocardial Infarction • CHF • CVA • Arrhythmias • Mitral Valve Prolapse • Coronary Artery Disease 	Can cause shortness of breath or pain leading to anxiety/agitation. “ “ Can cause palpitations and shortness of breath leading to anxiety. “ “
Gastrointestinal <ul style="list-style-type: none"> • Irritable Bowel Syndrome • Ulcers • Diarrhea • Constipation 	Can cause pain or if actively bleeding can decrease Hgb and cause hypoxia. May also feel anxious over their inability to get to the bathroom on time.
Metabolic <ul style="list-style-type: none"> • Electrolyte Imbalances • Hyper or hypothyroidism • Hyperglycemia • Hypoglycemia 	Confusion, lethargy, coma Confusion, combativeness, seizures, coma, hyperventilation,

<ul style="list-style-type: none"> • Pheochromocytoma 	<p>palpitations, tachycardia, cool, pale skin, clammy, diaphoretic. Can secrete large amount of epinephrine/norepinephrine and can cause anxiety and agitation.</p>
<p>Neuropsychiatric</p> <ul style="list-style-type: none"> • Early Stages of Cognitive Impairment • Memory Loss 	<p>Become agitated especially in early stages when they recognize they can not remember. Also, these behaviors can worsen with changes in routine or surroundings, i.e. with hospitalization.</p>
<p>Nutritional</p> <ul style="list-style-type: none"> • Vitamin B12 Deficiency • Trace Element Deficiencies 	
<p>Sensory</p> <ul style="list-style-type: none"> • PAIN • Impaired Vision • Impaired Hearing • Meniere’s Disease • Headache 	<p>Pain must always be assessed when patient is anxious and agitated.</p> <p>Anxiety in unfamiliar situations Anxiety</p> <p>Meniere’s can cause dizziness, hearing loss, tinnitus. Dizziness can lead to falls.</p>
<p>Other</p> <ul style="list-style-type: none"> • Drug Withdrawal • Drug ingestion <ul style="list-style-type: none"> Caffeine Thyroid Hormones Aminophylline NSAIDs (nonsteroidal anti-inflammatory drugs) Steroids Digitalis Glycosides OTC Sympathomimetic drugs i.e., ephedrine Cocaine Toxicity Hallucinogens Anticholinergic agents SSRIs (Selective serotonin reuptake inhibitors) 	<p>This is especially associated with ETOH, anxiolytic agents and sedative-hypnotic agents. Could be prescribed and /or not prescribed</p>

Adapted from Mastering Geriatric Care, Springhouse Corp., 1997

Attach C

Physical Conditions That Can Lead to Agitation

Cognitive Impairments

- Delirium
- Dementia

Trauma

- Severe burns
- Heat stroke
- Brain injury

Neurologic

- CVA
- Tumors
- Seizure disorders

Sensory

- Impaired hearing
- Impaired vision
- Communication losses
- Pain/discomfort
- Sensory overload
- Sensory deprivation

Pulmonary

- Acute hypoxic states
 - Pulmonary emboli
 - Pulmonary edema
 - Pneumothorax

Metabolic

- Hepatic encephalopathy
- Uremia
- electrolyte imbalances-especially sodium, potassium, magnesium, calcium
- Acid-base imbalances

Infectious Processes

- Meningitis
- Encephalitis
- Herpes simplex viruses
- Lyme's disease
- Sepsis

Pharmacologic Effects

- ETOH withdrawal
- ETOH intoxication
- Cocaine intoxication
- Adverse drug reactions

Adapted from Linda Gerdner and Kathleen Buckwalter, "Assessment and Management of Agitation in Alzheimer's Patients", Journal of Gerontological Nursing, April 1994, Vol. 99, No. 4, p. 13

Causes of Delirium: Acute Agitation

Brain Injury

- Concussion
- Contusion

Fevers**Hypothermia**

Attach D

Neurologic

- Postictal states
- Migraine headaches

Pulmonary

- ARDS (Adult respiratory distress syndrome)
- Hypercarbia

Cardiovascular

Hypotension

- Shock
- Myocardial infarction

Gastrointestinal

- Severe fecal impaction

Hospital Environment Stressors

- Ventilators

- Lack of privacy
- Loss of control
- Temperature extremes
- Fear
- Sleep-wake cycle disturbances

Adapted from Robin Haskell and Heidi Frankel, “Agitation”, AACN Clinical Issues, August 1997, Vol. 8, No. 3, p. 337.

Causes of Dementia: Chronic Agitation

Primary Dementia

- Alzheimer’s disease
- Creutzfeldt-Jakob disease

Vascular Diseases

- Multiple infarcts
- Vasculitis

Chronic Infections

- HIV
- Syphilis
- TB
- Sarcoidosis

Neurologic

- ALS (Amyotrophic lateral sclerosis)
- Multiple sclerosis
- Movement disorders
 - Parkinson’s disease
 - Huntington’s chorea
- Diffuse brain damage
 - Anoxia
 - Chronic subdural hematoma

Metabolic

- Heavy metal poisoning (i.e., lead)

Adapted from Robin Hadkell and Heidi Frankel, “Agitation”, AACN Clinical Issues, August 1997, Vol. 8, No. 3, p. 340.

Attach

Behaviors Associated with Chronic Agitation

Physically Aggressive Behaviors

- Hitting
- Scratching
- Grabbing
- Pushing
- Tearing objects
- Throwing objects
- Spitting
- Kicking

Physically Nonaggressive Behaviors

- Wandering
- Pacing
- Attempts to leave facility
- Intruding into other patients' rooms or staff offices
- Constant searching for objects or persons
- Inappropriate dressing or undressing
- Urinating in inappropriate places or containers
- Repetitive mannerisms
- Pulling out tubes
- Climbing out of bed
- Resisting cares (i.e., bathing, dressing, eating, taking meds, etc.)

Verbally Aggressive Behaviors

- Cursing/swearing
- Screaming/yelling
- Making strange noises (i.e., growling like an animal)
- Angry outbursts

Verbally Nonaggressive Behaviors

- Constant requests for attention
- Complaining/whining
- Negative talk
- Singing
- Rambling, nonsensical sentences
- Nonverbal vocalizations (i.e., moaning)
- Repetitive questions/sentences, calling out or calling for a parent or caregiver

Adapted from Samer Nasr and Dan Osterweil, "The Nonpharmacologic Management of Agitation in the Nursing Home: A Consensus Approach", Annals of Long Term Care, May 1999, Vol. 7, No. 5.

Comparisons Between Delirium and Dementia

	Delirium	Dementia
Onset	Sudden onset that can be given a fairly precise date	Slow onset that can't be dated; usually no history of psychological problems
Symptom Duration	Rapid fluctuation of symptoms, usually not lasting more than 1 month	Long duration of symptoms, that is present for months and often years

Reversibility	Is often completely reversible	Is generally not reversible and is usually progressive
Orientation	Disorientation is present from the onset	Disorientation only in the later stages, usually after years
Hallucinations	Common from the onset	Occur only in the later stages
MSE* Answers	Responses are generally incoherent	Patient tries hard on MSE* test; achieves “near misses”
MSE* Results	Repetition of exams show wide fluctuations in results	Repetition of exams show fairly stable results, that gradually decline over months to years
Level of Consciousness	Clouded and changing levels of consciousness	Consciousness is unaffected until the later stages
Attention Span	Very short	Remains fairly stable until the later stages
Memory	Sudden onset of memory loss	Conceals or is unaware of memory losses; short term memory is affected most severely
Mood	Mood is labile, changing from moment to moment	Mood fluctuates, but changes from day to day
Physiologic Changes	Prominent	Minor or absent
Activity Level	Hyper- and hypoactivity are common and changing	Activity level changes occur in the later stages
Sleep-Wake Patterns	Disturbed sleep-wake cycles, varying from hour to hour	Sleep-wake cycles may be varied with day-night reversal, but not by hour to hour

Attach F

*MSE=Mental Status Exam (i.e., Folstein Mini Mental Exam)

Adapted from S. Scott Paist III, MD and Jeffrey Roth Martin, MD PostGraduate Medicine, Vol.99/No 5/May 1996

Possible Symptoms/Behaviors of Mental Health Disorders

(Symptoms and behaviors below are possible for each Disorder, however are probably not experienced by everyone with the Disorder)

Conditions	Assessment Criteria
Schizophrenia	<u>Symptoms</u> - hallucinations (auditory most common), delusions, unclear thinking, disorganized speech and behavior, apathy, poor social functioning <u>Behaviors</u> - Preoccupation, confusion, odd statements and/or behavior, withdrawn, distracted, talking to self, avoids others.
Bipolar Disorder (use to be called Manic/Depression)	See Major Depression for Depression Phase Manic/hypomanic phase <u>Symptoms</u> - elevated or irritable mood, inflated self esteem, decreased need for sleep, hyper-verbal, distractible, thoughts and behavior flit from one thing to another quickly, high energy. <u>Behaviors</u> - mood changes quickly and often, talking fast and loud, intrusive, impatient, saying and doing inappropriate things (like they have a lot of money or they are a famous person) hyperactive, risky behavior.
Major Depression	<u>Symptoms</u> - depressed mood, decreased interest or pleasure in

	<p>things, change in weight and appetite, problems with sleep, psychomotor agitation or retardation, lack of energy, thoughts of worthlessness and guilt, problems with concentration and thinking, thoughts of death, thoughts of suicide.</p> <p><u>Behavior</u> - tearful, nervous/stressed, excessive sleep or sleep disturbed, unmotivated to do things or to be with others, blames self, indecisive, not eating or caring for self, talks about suicide or death or makes gestures or attempts.</p>
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Attach G

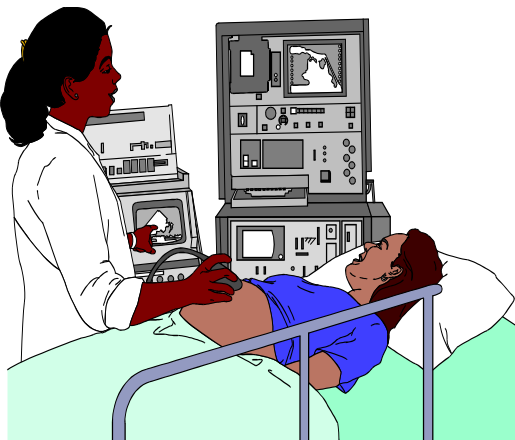
<p>Anxiety Disorders</p> <ul style="list-style-type: none"> • Panic • Agoraphobia • Specific Phobias • Obsessive-Compulsive • Posttraumatic Stress • Acute Stress • Generalized Anxiety Disorder 	<p><u>Symptoms</u> - can vary widely depending on the specific disorder. Palpitations, sweating trembling, shortness of breath, chest pain, dizziness, fear of dying.</p> <p>Person has anxiety triggered by crowds or public places. anxiety triggered by excessive fear of something in particular.</p> <p>Recurrent thoughts, impulses, images cause anxiety and may be paired with repetitive behaviors to reduce stress.</p> <p>physical and psychological symptoms caused by a traumatic event and is triggered again and reexperienced in various ways.</p> <p>A traumatic event is witnessed, but causes dissociative symptoms (numbing, dazed, derealization, depersonalization and other anxiety symptoms).</p> <p>Excess worry and anxiety with symptoms of restlessness, fatigue, concentration problems, irritability, sleep problems.</p> <p><u>Behaviors</u> - behaviors an vary widely depending on disorder, but generally people with Anxiety Disorders will go to great lengths to avoid the situations or stimulus that tends to trigger their anxiety, worry and be preoccupied excessively about the trigger(s), affect ones life mildly to very significantly depending on the disorder and it's severity.</p>
<p>Substance-Related Disorder</p>	<p><u>Symptoms</u> - intoxication, tolerance, withdrawal symptoms (varies according to substance), dependence.</p> <p><u>Behaviors</u> - irritability, agitation when needs not met, disruptions in relationships, medication and drug seeking behavior, denial or</p>

	minimization of substance problem.
Personality Disorders <ul style="list-style-type: none"> • Antisocial • Borderline • Paranoid • Histrionic • Narcissistic • Others 	<u>Symptoms</u> - misperceiving/misinterpreting events and other people, wide lability and intensity of emotional response, interpersonal problems relating to others, poor impulse control. <u>Behaviors</u> - labile mood, see things as black and white (no gray), tend to over react, act impulsively (even to harming self), irresponsible, and tends to blame others, feels manipulative, unsuccessful in relationships, potential for getting in trouble with the law.

Factors for Patient Assessment Related to Behavior Management

Assessment Factor	Criteria for Assessment
Assesses patient's past medical history as possible cause of behavior.	Know the patient's history gathered through the medical record, Kardex, or other sources such as the staff, family or other facilities. Review the medical records for past history, lab values, medications, O2 and other treatments. Does patient have a past history of physical or sexual abuse or is a victim of torture.
Assesses patient's current medical condition for cause of behavior or symptoms of mental illness.	Observe current behaviors, speech, affect, mood, signs or symptoms. Observation of whole patient for behaviors, sign and symptoms, body appearance and condition and affect. Converse with the patient to assess clarity, content, orientation and mood. Formal testing such as mental status exam, Functional Assessment Tool or Folstein Mini Mental Status Exam.
Assesses for symptoms of withdrawal, organic brain syndrome, Alzheimer's, trauma, pain chemical imbalances and O2 levels	Observe behavior Use assessment tool (i.e. Alcohol Withdrawal Protocol). Monitor vital signs. Know signs and symptoms of intoxication or toxicity both acute and chronic Know signs and symptoms of medical and psychological conditions Know results of: Glasgow Coma Scale. Pain assessment. Lab results for: Specific electrolytes - especially blood sugars - accu check Drug toxicity levels (Dilantin and Digitalis) O2 saturation levels.
Seeks input from family, significant others on behavior.	See section on disease history.
Assesses patient's ability to communicate needs and concerns. Assess sight, hearing and comprehension.	Know patient's ability to communicate. Know if there are language barriers. Know if there are any deficits in sight or hearing and if patient uses correct devices, i.e. glasses and hearing aids. Know results of formal testing and do informal testing of patient's abilities Assess patient's ability to follow directions. Know mental status exam results.

<p>Seeks information and assesses if this is a change from baseline for patient.</p>	<p>Check history, medical record, and records from other facilities family members and visitors. Know baseline level of functioning including cognitive level, ADL functioning, abilities/disabilities, current treatments and medications and w interventions have worked or not worked in the past.</p>
<p>Assesses need for basic things such as food, water, safety and mobility.</p>	<p>Presence or absence of Foley catheter. Are tube feedings present? Presence of IV or other lines for medications or treatment. Danger of patient “pulling out tubes or lines”. Can they feed themselves or get fluids on their own? Know I & O results. Observe gait and transferring ability Observe safe transfer and use of transfer devices Are they using mobility devices safely (canes, walkers, crutches and wheelchairs etc.)? Assess strength. Assess for rehabilitation needs and for appropriate referrals. Assess risk of falling out of bed or chair.</p>
<p>Assesses cultural differences that may impact interpretations.</p>	<p>Know cultural behaviors and beliefs of patient such as:</p> <ul style="list-style-type: none"> • Who is the decision-maker for the family unit (in case this is not a typical role of patient)? • Who patient can and can not interact with. • Is eye contact appropriate for their culture? • Are certain types of touching not appropriate? • Calls patient by the name appropriate for their culture and age. • Ask patient or family about preferences, diverse needs and background • Ask patient and family about special needs.



**Use of Alternatives to Restraints
Factors for Consideration**

Factors	Criteria
Plan with family best way to handle behavior.	<p>See history section. Consult with family about restraint application. Know what communication style is effective. Know the way the patient handles and expresses emotions. Ask if family or friends are willing to sit with patient. Know beliefs of family on restraint use. What is family's belief about controlling falls above all else? Enlist family, friends and others to reinforce the plan of care and what's appropriate and inappropriate behavior.</p>
Problem solve with patient.	<p>Talk with patient about their insight into the issues leading up to restraint use and do they have any suggestions or ideas about managing their symptoms. What is patient's belief about controlling falls above all else? Demonstrate willingness to negotiate with patient as appropriate.</p>
Assist patient to exercise self-control to extent possible.	<p>Provide opportunity for patient to express their wishes around the use of restraints. Contract with patient about activities. Allow patient to exercise the amount of control available to them in the situation. (i.e. the timing of cares, treatments, tests or other activities. Orient patient to the unit routine and rules, as appropriate. See patient problem solving section.</p>
Orient patient, as needed, to reality and physical environment.	<p>Orient to person, place and time frequently. Use calendars, clocks or white boards in room appropriately.</p>
State expectations of patient's behavior and progress.	<p>State to patient what staff is expecting of their behavior. Provide direction, limit setting and feedback especially when patient is confused, uncertain or unsafe Limit setting should be:</p>

	<p>Patient focused – not for staff convenience. Clear, concise, specific and focused on patient behavior. A limit is stating a behavioral expectation and then a consequence for complying or not complying. (“Mary, if you can stop putting on your car light for 15 minutes I will come in and bring you some ice cream. This is an example of positive consequences, which can be more effective than negative consequences.) Allow the patient a “face saving” option. May help to reduce power struggles.</p>
Give directions and explanations to patient staff.	<p>Establish a plan with the patient and family and keeps them informed of changes. Communicate plan to all staff.</p>
Maintain safe and therapeutic environment conducive to non-violence (noise control, lights people).	<p>Control noise, lights & people as needed. Determine what patient perceives as threatening</p>
Utilize other disciplines and staff as needed. Report significant changes to appropriate team member.	<p>Ask assistance as necessary. Consult with house supervisor or other units and disciplines outside of your area. Report to physician, other health care workers and unit staff. Keep charge nurse informed about patient’s current condition and changes.</p>
Use medications and other appropriate treatments for underlying disease.	<p>Aware of medications side effects and interactions. Make sure medication and treatments are appropriate.</p>
Listen to patients concerns, feelings, validating them (de-escalation).	<p>Use positive active listening skills. Focus on the patient’s behavior not personality. Use non-judgmental approach. Be a good listener by letting the patient tell their story. Give full attention to patient and situation. Focus on the here and now. Use the person’s correct name. Convey a positive, respectful, warm, and helpful attitude. Use direct eye contact (favored in most cases), face or lean toward the patient, use encouragers like; “yes, I understand” etc. and nod head appropriately at times. Relay empathy by focusing on feelings. (i.e.. “I can see why that would make you angry.”) Use open-ended questions to gather information. Use ‘I’ and “we” statements to personalize and enlist their cooperation. Use skills like summarization, paraphrase, and restatement to clarify information. Be clear, concise, and direct in verbalization.</p>
Know own trigger points and when to remove self as an escalating factor.	<p>Avoid personalizing what is said (even though it feels personal). Maintain own self-control and professionalism.</p>