Behavior Management and De-escalation

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HEALTH SOLUTIONS

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Overview

- Why is this important? CMS changes and regulations
- Wearing their shoes
- Defining a behavior
- Anatomical correlates
- Common behaviors
- Common causes of behaviors
- Defining:
  - De-escalation
- De-escalation
- Tools for effective communication

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New Changes

- Beginning October 24, 2022 surveyors will be using these new guidelines
- Focus on psychiatric diagnoses and inconsistencies within documentation

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Regulatory Grouping: Pharmacy Services

Pharmacy Services

- §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--
- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
- §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

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- Put yourself in the residents' shoes for a minute:

-You are a 34-year-old who has a history of homelessness, schizophrenia, and substance use. You have been at the facility for 5 days and your behaviors are yelling, refusing medications, and care.

- Wear their shoes:
  - What is it like to be schizophrenic?
  - What are you adjusting to?
  - Are you withdrawing? In pain? Scared?

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Defining a Behavior

- What is a behavior? What constitutes a “behavior?”
- Is yelling because they are hungry or in pain a behavior? Is this behavior out of character for the resident? An issue at all?
- Is normalizing behaviors an issue?

Document, document, document!

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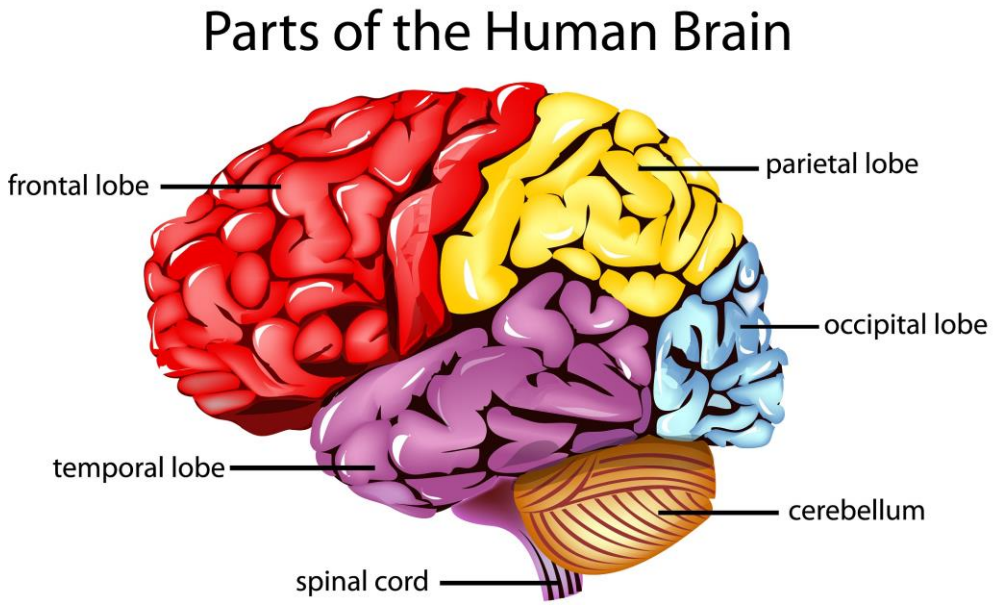

Associated cognitive issues

- Homelessness
  - Toxic stress, depression, SU/SA
  - TBI (53%) (Hwang, et al. 2008)
- Substance use/abuse
  - Affects positive forms of motivation, engaging in socialization, eating, irritability, solve problems, make decisions, reduces impulse control (Basal Ganglia, Prefrontal Cortex (PFC), and amygdala)
- Psychosis
  - Neuronal loss, dopamine and structural neuronal changes, PFC and temporal areas (Karlsgodt, et al., 2010) – PFC- decision making planning, impulse inhibition, cognitive control and goal-directed behavior

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What are the most common challenging behaviors?

- Obscene or abusive language
- Socially inappropriate sexual behavior
- Urinating, defecating in inappropriate places
- Hoarding
- Wearing too few or too many clothes
- Poor safety awareness
- Attention seeking behavior (calling out)
- Territoriality
- Resisting care, Exit seeking, pacing

What are the most common causes of challenging behaviors?

Environmental vs. biological

- Changes in living conditions
- Medical issues (e.g., dementia, pain)
- Hunger
- Feeling hot/cold
- Sleep (not enough/too much)
- Psychotic disorders
- Bored, afraid, lonely
- Cultural, language differences

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- The ABC's of behavior:
  - Antecedent – what happened before the behavior occurred
    - Pain, hunger, hot/cold, call light not answered, feeling ignored, lonely, etc.
  - Behavior – what the resident did
    - internal vs external behavior (pain vs hitting/yelling)
  - Consequence – what happened immediately after the behavior
    - Received pain medications, attention, etc., can increase or decrease likelihood of behavior reoccurring

A: The patient wants to smoke

B: The patient yells out

C: Receives attention/goes to smoke

Help change the cycle: Redirect/refocus, reinforce positive behaviors.

(Friedman, 2001)

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- De-escalation
  - Consists of variety of techniques aimed at reducing violent and/or disruptive behavior. (NICE, 2005 as cited in Price and Baker, 2012).
  - Psychosocial intervention for management of aggressive or agitated behavior (Du, et al., 2017)
- "'The assault cycle' typically includes a trigger phase, escalation phase, crisis phase, recovery phase and depression phase (Kaplan 1983). De-escalation is a complex range of skills designed to abort the assault cycle during the escalation phase, and this includes both verbal and non-verbal communication skills" (CRAG, 1996), as cited in Du, et al. 2017).

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Defining:

Active triggers

Actions that are intrusive in nature: Wandering into other resident's rooms/personal space, Taking belongings

Passive triggers

Environmental factors: Boredom, Attention, Communication deficits

Ex: The type of work they previously did may provide insights into how to help them, why their behavior is occurring.

(Snellgrove et al., 2013)

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Working with active and passive triggers

- Identify triggers/knowing the resident
- Redirect/refocus
- Provide alternatives
  - Activities! Bingo, crossword puzzles, poker night, jeopardy, painting, drawing, etc.

(Snellgrove et al., 2013)

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De-Escalation

Staff skills

- Non authoritarian, express genuine concern, honest, supportive, non-judgmental-ability to empathize—validates feelings, reduces aggression, helps gain patients trust (Price and Baker, 2012)
- Staff temperament, self-reflection, control countertransference, acknowledging when it is best to seek additional help (Richmond, 2012)

REMAINING CALM

- Communicates trust to the patient that they are trusted not to become violent, calmness conveys staff is in control of the situation, staff fear can increase anxiety, feeling unsafe.
  - HOW DO I REMAIN CALM?
    - Focus on the assessment, acknowledge feelings don’t deny them, suppress personal feelings towards patient-perceive behavior as out of the patient's control.

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De-escalation

- Verbal and non-verbal skills
  - calm, gentle, soft tone; tactful language, Humor?
  - Body language – posture, proximity, eye contact, body language should express concern for the patient
  - Active listening, empathizing, understanding (Price and Baker, 2012)
  - Positive regard for the patient and positive attitude, empathy for impairment- psychosis, schizophrenia, homelessness- went from no rules to a lot of rules- adjustment period
- Intervening
  - Establishing a bond with resident increases autonomy and trust in staff, confirms their (pt) humanity and sense of equality
  - "Aggression is often a response to lost dignity, and feeling respected enables the patient to reclaim their sense of dignity and reduces the need for further aggression (Carlsson et al. 2000). Punitive approaches must be avoided (Lowe 1992)."

Price and Baker, 2012

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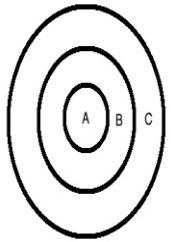
De-escalation:

When to intervene?

- As early as possible, but PRN.
  - Knowledge of the patient, is the behaviors-normal/abnormal for the patient, impact behaviors have on others – DOCUMENT, DOCUMENT, DOCUMENT
  - **Find out reason for aggression, ask patient what the problem is, what can be done to resolve it, and what helps them feel calmer**
  - Something simple like a certain type of shampoo, or too cold in their room, etc.
  - NO ULTIMATUMS, THREATS, POWER STRUGGLES

Safe conditions

- Assess for appropriate level of staff support to de-escalate, team effort
- Assess environment (Richmond, et al. 2012) A, B, and C --Immediate surroundings and objects- vigilance, situational awareness
- Remove patient from area if doing so won't further aggravate patient.



Price and Baker, 2012

De-escalation

- Strategies
  - Instinctive, flexible, based on patient needs
  - Balance support and control
  - Proportionate to risk posed by patient
  - Allow patient to express feelings, communicate openly
  - Offering alternatives to aggression
    - Cooling off period
    - Alternative activities
    - “Face saving” alternatives- reducing aggression without without losing dignity
  - Goal is to empower patient, so they feel they are choosing to de-escalate and positively reinforce this

Price and Baker, 2012

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De-escalation of an immediate threat:

- Maintain 2 arm lengths from the patient
- Keep hands visible, non clenched
- Stand at an angle to patient but in direct view
- Calm demeanor, open body positioning, congruent to what you are saying
- Do not challenge, insult

(Richmond, et al 2012)

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De-escalation of an immediate threat:

- First person to engage de-escalates – limit the amount of communication as too many people talking at the pt will increase confusion
- Remove bystanders/nonessential personnel from area
- Use short simple vocabulary
- Give them time to process what is being said

(Richmond, et al 2012)

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De-escalation of an immediate threat:

- Look for “free information” – what the patient says, body language, utilize knowledge of past encounters with them
- Offer a choice – propose alternatives to violence, offers acts of kindness (blankets, magazines, TV, food, drinks, etc.) to stall aggressive behaviors.
- DO NOT DECIEVE THEM BY PROMISING SOMETHING THAT CANNOT BE DELIVERED

(Richmond, et al 2012)

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- Helping reduce problem behaviors:
- Behavioral reinforcement
  - Positive reinforcement- praise for doing well, taking their medications, showering, not yelling/screaming out. Complementing residents for positive behaviors increases likelihood they will perform behavior again
    - Example: Pt who is usually yelling, isn't = praise!
  - Negative punishment– taking something away to decrease a desired behavior
    - Example: denying smoke breaks for bad behavior….not a good idea.

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Successfully Working with Problem behaviors

- Redirect, validate, praise, ask them for their help using simple language, yes/no questions, active listening-reframe/repeat what you are seeing/hearing

Unsuccessfully working with Problem behaviors

- Rush them, arguing, reasoning with them, pointing out forgetting, speaking to them in a negative or dismissing tone, yelling back

When the patient states, “I want to get out of here,” the clinician can respond, “I want that for you as well; I don't want you to have to stay here any longer than necessary; how can we work together to help you get out of here?”

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Questions to ask yourself:

- Put yourself in their shoes; Look at their body language, how they might be feeling?
- What lead to the behavior? Did something trigger the behavior?
- Are the patient's basic needs being met? (Is the patient hungry, in pain, bored, needing a brief change or pain medication?) Increase/decrease stimulation; Use distraction; redirection, attend to their needs
- Did your reaction help/hurt the situation? If it hurt, then change your response. No yelling, baby talk, etc.
- Does the resident work better/worse with someone else? Ask for help from other professionals or family members that the individual is most comfortable/familiar with

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Thank you for your time!
Any Questions?

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