Assaultive Crisis Intervention Training (ACIT): Security Personnel

Learning & Development

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Building healthier communities together

Revised: 4/20, 3/23 MC

Purpose for Training

Samaritan Health Services has created the following training to meet the CMS 482.13(f) and ORS 654.414 requirements for education related to assault prevention and restraint and seclusion training.

Assignment of this training has been approved by the Vice President of Human Resources.

Objectives

- Identify common reasons for workplace violence in healthcare.
- Identify individuals most likely to become aggressive.
- Recognize escalating behavior.
- Describe de-escalation strategies.
- Describe security personnel role in physical intervention and application of restraints for violent behavior.

Introduction

According to the U.S Department of Labor and Occupational Safety and Health Administration (OSHA), violence in the workplace results from a variety of internal and external sources.

Within the emotionally-charged field of medicine, healthcare professionals are considered to be at an especially high risk for injury.

Whenever there is interaction between healthcare workers and patients, visitors, and coworkers, there is a potential for violence.

Safety is the priority for **everyone** at SHS!

Motivators for Assaultive Behavior: Why Do People Become Violent?

Theories have shown that the two most common motivators for assaultive behavior in health care are:

Fear and **Frustration**

Violence is the outcome of people defending themselves:

- Against a threat (real or perceived)

And

- A temporary loss of control over their behavior

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Predicting Assaultive Behavior

Any person has the potential to become assaultive regardless of gender, age, background, etc.

Maintaining situational awareness is one of the most important factors when aggressive behavior.

Predicting Assaultive Behavior (Cont.)

- Certain factors/conditions have been shown to help identify those with an increased propensity for violence such as:
  - Those with a prior history of aggression or assault
  - Substance use/abuse
  - Lack of formal education
  - Diagnosis of mental health disorders
  - Age (younger people are more likely to display assaultive behavior)

(Varela, 2013)

Preparing for Aggressive Patients

- Whenever possible, review any available patient information related to a potential for aggressive behavior prior to interaction.
- Be alert for signage specific to aggressive patients.
  - SHS utilizes gray "stop" signs to alert staff to the potential for aggression with select patients.

If you see this sign, stop and ask for more information about the patient

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Violence Assessment: Signs of Escalating Behavior

- Common indicators of escalating aggressive behavior are…
  - Tense posture
  - Clenching fists, finger tapping
  - Pacing
  - Restless or fidgety
  - Heavy sighing
  - Intense staring
  - Large, animated movements

Personal Response to Aggression

- Our personal reaction to aggression/violence can negatively impact our response to it.
- The fight or flight response can cause extreme reactions so we must be prepared prior to instances of aggression.
- Having a way to calm yourself in the moment is an important part of a safe conclusion to an aggressive event.
- Taking deep breaths, counting to ten in your head or other simple actions can help you stay regulated.

De-Escalation

- Remain calm
  - Take some deep breaths to help you relax during the interaction
- Don’t take things personally
  - Those working with potentially assaultive patients benefit from knowing their own triggers to avoid personal escalation
- Maintain a non-threatening posture and maintain at least a 4-6 foot distance from an aggressive person at all times.
- Stand at a 45-degree angle to the person and **keep your hands visible at all times.**

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De-Escalation (Cont.)

- Use a calm and low tone of voice.
  - Talking to an escalated person in a low volume is a good way to get them to lower their own voice
- Speak in simple sentences of five words or less.
- Be clear and concise and keep communication simple.
- Use “I” statements over “you statements such as…
  - “I want to help you be calm” rather than “you need to calm down”
- Allow time for the individual to process information and respond before providing additional information.

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De-Escalation (Cont.)

- Maintain eye contact 90% of the time when they are talking and 60% of the time when you are talking.
- Be aware of your non-verbal communication (body language) at all times.
  - Crossed arms and lack of eye contact can be interpreted as dismissive, uncaring and potentially threatening.
- Listen empathetically.
  - People know when they are being ignored, even when in crisis, and this action has the potential to cause increasing agitation.

De-escalation (Cont.)

- Set clear limits with the individual.
  - Be respectful and reasonable with limit setting
  - Be sure to demonstrate your intent to help the person
- Offer choices when able.
  - Most assaultive behavior is related to an unfulfilled need
- Validate the persons anger and/or frustration.
- Attempt to relocate the individual to an area with less stimuli if possible.

Aggressive Behavior Response

- **“Security alert – aggressive behavior”** is the overhead page used in all Samaritan hospitals to indicate a needed response related to aggressive or assaultive behavior.
- The page will be accompanied by the location of the event.
- The initial response of staff and security is known as a **“show of force”**.

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Show of Force

- Response to an aggressive behavior alert in known as a show of force.
- The show force is a de-escalation tactic utilizing staff in numbers to demonstrate potential use of restrictive measure.
- In many instances an aggressive person will choose to calm rather than “fight” with responders.

Note:

The use of physical interventions (restraint, hands on, etc.) is at the discretion of the RN leading the intervention team.

Physical Intervention

- Use of physical or “hands-on” interventions requires that **all other less restrictive interventions have been attempted and failed.**

- Going “hands-on” or use of any other form of restraint should never be used for staff convenience or because of the time commitment needed for de-escalation.

Physical Intervention (Cont.)

- All members of the intervention team must be free from limitations that would put themselves and others at risk for injury.
- Those participating in physical interventions should have at least a 100% advantage over the subject.

Physical Intervention: 100% Advantage

- Team members participating in physical interventions should have at least a 100% height and weight advantage over the aggressor.

- The combined sum of the teams height and weight should be approximately double that of the aggressive patient.

  - i.e., if an aggressor weighs 250 pounds and is 6 feet tall, the combined height and weight of responders should equal 500 pounds and 12 feet in height.

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Physical Intervention (Cont.)

- Physical intervention is only done with an adequate team of people.
- The team consists of:
  - **Leader: RN**. Calls for hands on/off, assigns team roles as necessary, monitors on-going situation, is the only voice directing team.
  - **Arm restraint:** two people (**Security or SHS staff**) that will capture and control the movement of the patients arms. These responders will also be responsible for moving the patient if need be.
  - **Leg restraint:** two people **(Security or SHS staff)** who will restrict the movement of the patients legs.

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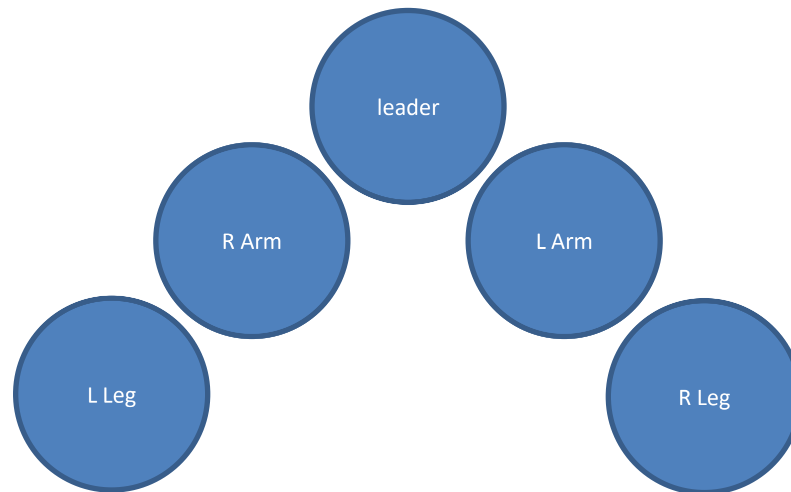
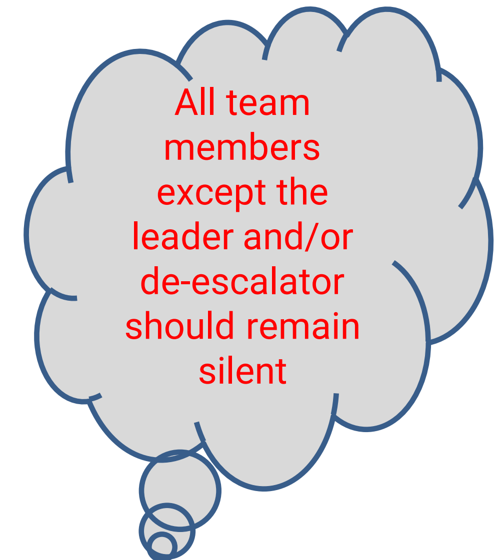
Team Formation

- Team members should arrange themselves in a specific formation (below fig.) to aid in the intervention.
- This formation also serves as an additional show of force in an attempt to de-escalate the patient.





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Going “Hands On”

- All team members should remain quiet unless necessary to maintain safety.

- The leader or RN in charge of the team will initiate physical restraint by saying **“Hands on”.**

- All team members will swiftly advance forward to capture their assigned limbs at the same time.
  - Arm controllers will capture the assigned limb using the same hand.
    - i.e., staff’s R hand will make first contact at the patients R wrist and vice versa
  - Leg controllers will kneel behind the patients heel using the opposite knee.
    - i.e., staffs R knee will be on the ground behind the patients L heel and vice versa

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Hands On

- Regardless of hands-on technique used, **do not let go to get a better grip.**
- Restraint team members should refrain from speaking unless necessary.
  - i.e., informing the team that you're losing your grip would be a necessary reason to speak up.
- The restraint should be discontinued if it becomes unstable or unmanageable.

Release from Hands On Restraint

- The RN in charge will determine when to release a hands-on restraint or move the patient to violent restraints.
- Patients should be monitored for increasing signs of aggression during release.
- Staff will release the patient slowly but steadily in the reverse of the hands-on process.
  - Stay alert for signs of increasing agitation and the potential need to re-restrain
- Staff should return to their starting position after release.

Physical Intervention Return Demonstration

Hands-on training for physical interventions will be completed with a Security supervisor.

Use of Restraints

- The use of restraints is in accordance with SHS policy and procedure, “Use of Violent Restraint”, as well as state and federal guidelines.
- Restraints should be used only after all other interventions have been tried and failed.
  - Never for staff convenience or retaliatory purposes
- Patients requiring restraint must be an immediate threat to themselves and/or others.
- Only **trained** SHS and Premier Security staff may apply violent restraints.

Use of Restraints (Cont.)

- Only restrain as a team, 5-10 people.
- No hands-off until each restraint cuff placement has been verified by an RN.
- Maintain compassionate care for patient.
- Avoid traumatization, do not remove clothing unnecessarily, do not spread legs.

Posey Neoprene Locking Restraints

- SHS utilizes Posey neoprene locking restraints for violent restraint.
- There are two sizes denoted by color:
  - Blue: utilized for arm restraint and are secured at the wrist.
  - Red: utilized for leg restraint and are secured at the ankle.

Restraint Application Return Demonstration

- Demonstration of restraint application will be completed with your supervisor.

Release from Restraints

- Restraints should only be removed after a thorough RN assessment of the patients mood, level of agitation, ability to communicate, etc.
- Restraints should be released all at the same time, never one off then wait, etc.
- Restraint removal ideally utilizes the same amount of staff as application (5-10). Security staff may be called to assist.
- Release restraints from the patient prior to releasing them from the bed.

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Event Debriefing

- Debriefing is a short 3-5 minute meeting that provides an opportunity for team input in order to improve processes for the safety of staff, patients, and visitors.

- De-briefing should only take place when team members are at baseline and should include as many people involved as possible.

- Questions to ask include but are not limited too:
  - Is everyone OK?
  - What went well?
  - What could be done better next time?

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Documentation

- Security officers are responsible for signing documentation generated by the code leader.

- Regardless of outcome, Security Officers will generate an aggressive behavior case report in Report Exec related to the event.

- Security staff will also file an aggressive behavior report in RLDatix.

Use of Law Enforcement

- Law enforcement should be utilized when staff feel the situation cannot be safely managed or a weapon is involved.
- The person calling 9-1-1 should…
  - Identify self and give history of event.
  - Identify the assistance needed.

Leader or person in charge:

- ✓ Makes contact with responding officer(s)
- ✓ Provides direction to team including officers

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Safe Management Techniques: Evasive Maneuvers

<u>Methods to avoid injury include</u>:

- Positioning yourself closest to the door.
- Staying 4-6 feet away from volatile, aggressive people.
- Calling for backup assistance.
- Covering up and attempting to evade.
- Deflecting and moving away from any attempts to hit.

Summary

- Fear and Frustration, as well as unfulfilled needs, are the most common reasons for violence in healthcare.
- The assault cycle has six phases which demonstrates that cognitive ability diminishes as anger increases.
- Those with a prior history of violence, substance users/abusers and younger people are most commonly associated with violence.
- De-escalation strategies vary but involve communication and self awareness.
- Premier Security staff are members of the Code 5 response team and assist with restraint application and removal.
- Code 5 remains the overhead page for behavioral response at SHS hospitals. Code 5 is a show of force/concern but can also involve physical intervention.

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