United States Department of Veterans Affairs

Prevention and Management of Disruptive Behavior
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Introduction

Prevention and Management of Disruptive Behavior: Introduction

Welcome to the Prevention and Management of Disruptive Behavior (PMDB) course.

To receive credit for this course, you must complete each required lesson and pass the assessment at the end of each lesson. As you navigate the course, the lessons are listed in the course menu and are accessible for review. An assessment will appear at the end of each lesson. The score from each end of lesson assessment will count as your final course score. A minimum score of 80% is required to complete this course.

1. Observation and Assessment
2. Predisposing and Precipitating Factors
3. Stress Levels and Staff Intervention
4. Patient Record Flags
5. Sexual Assault Prevention
6. Law Enforcement and Violence Prevention

Violence Prevention and Awareness Training

Violence Prevention and Awareness Training

This web–based training is intended to be an introduction to and review of basic concepts in the prevention and management of disruptive behavior and violence in the workplace.

Objectives you should achieve by the end of the course are:

1. understanding that prevention is the key to reducing disruptive behavior and violence;
2. identifying potentially disruptive situations and behaviors;
3. understanding factors that increase violence risk;
4. knowing how to report disruptive behavior and violence;
5. learning techniques to identify and prevent sexual assaults; and
6. identifying the role of law enforcement in preventing workplace violence.

Advanced Prevention and Management of Disruptive Behavior Courses

After completing the online PMDB training, contact your supervisor or facility education office if you would like to sign up for the following PMDB courses offered in a classroom setting.

Observational and Verbal Skills

Learn and practice how to identify and verbally de–escalate disruptive behavior. This training emphasizes early intervention to prevent situations from escalating to physical violence.

Introduction

Personal Safety Skills

Learn and practice escape techniques that minimize immediate danger and allow time to respond appropriately to situations involving physical violence.
Therapeutic Containment
Learn and practice team-based techniques for physically containing a disruptive or violent individual while minimizing potential injury to the contained person and staff.

Coworker Stories

Narrator
Many of your co-workers have used techniques they learned in the PMDB training program to de-escalate potentially disruptive situations.

Co-worker in an Office
I was interviewing a patient in my office and he suddenly grabbed my arm. I used the wrist release and then told him "Sit down!" with a "stern mother’s voice" — surprised us both and it worked! I don’t know how I would have handled it without this training.

Co-worker in a Parking Lot
Several months ago, we had an incident at the front entrance. An intoxicated man came into the facility and grabbed one of the nurses. She had taken a PMDB class and knew how to get out of his grasp. After she escaped, she left the area and notified the hospital’s response team. When I arrested him, I found he had a knife. I was really impressed with how well we worked together. I think everyone should take this course.

Co-worker in an ER Setting
A while back, I took a PMDB course with a bunch of other people. It was great. Then, a couple of months ago a patient grabbed me hard when I was going to the ER. And, I was able to get out of his grab, and an officer was there and intervened while I called the response team. So, I was able to help the patient get the right help and he always apologizes now when he sees me in the clinic.
Observation and Assessment

Observation and Assessment: Introduction

This lesson provides insight into Observation and Assessment. In this lesson, you will learn to:

1. identify different levels of disruptive behavior;
2. identify causes of disruptive behavior that may lead to violence against an individual;
3. recognize strategies for prevention of a disruptive behavior;
4. associate the ongoing interactive assessment to its influence on the outcome of a situation; and
5. identify best practices for keeping your environment safe.

Disruptive Behavior Continuum

Any behavior ranging from annoying to violent can be considered disruptive if it threatens the safety of those involved, or appears to be escalating in that direction. If this happens, you might need to intervene to de-escalate the situation.

Causes of Disruptive Behavior

Experiences and Interactions

There are many causes of disruptive behavior. Often, violence is an attempt to regain control or to make things right when a person feels wronged.

Fear and Frustration

Fear

- Feeling uncertain or confused about what is happening
- Afraid of bad news or disability related to medical illness

Frustration

- Waiting in long lines
- Being sent to several places for help
- Dealing with paperwork

Poor Health, Pain, and Memory Loss

Poor Health or Pain

- Multiple blood tests or delay in getting results of tests
- Mood changes due to pain or as side effects of pain medications
- Recovery from surgery or other procedures that can cause delay in getting back to "life as usual"

Memory Loss

- Forgetting to take medications that help control mood and behavior
- Misremembering information provided by the treatment team
Anger and Intimidation

Anger
- Not getting desired or needed information, services, or results
- Feeling disrespected or talked to like a child

Intimidation
- Feeling pressured to make decisions without enough information
- Receiving unhelpful advice or sarcastic remarks

What About You?

If you are like most people, you can imagine a situation in which you would physically attack another to protect yourself or your family.

Have you ever slammed a door or thrown something? We all have at least thought about it and may have even acted on it when angry enough.

Remember: Anyone may become violent in order to regain control of a situation.

Disruptive behavior can be made worse by two factors:

1. predisposing factors — unique internal qualities every person brings to a situation, often described as what is going on inside a person (thoughts, feelings, perceptions, memories); and
2. precipitating factors — events or experiences in the moment that can trigger escalation to violence, often described as what is going on outside a person.

A person who is disruptive or violent can be influenced to help regain a sense of control. It is important to realize that you are part of what’s happening and you can dramatically influence the outcome. With a little training, you can learn to turn a negative situation into a positive one.

Prevention as a Strategy

Prevention is the key to making sure a negative situation does not escalate to a disruptive or violent incident.

The first step in prevention is to have an understanding of the three contributing factors that need to be assessed in any situation. These factors make up the "Ongoing Interactive Assessment."

- Self
- Others
- Environment

Each of these factors interacts with each other in both positive and negative ways to influence a situation. Your ability to assess and modify these factors can have a significant impact on the outcome of a situation.

Assessment Strategies

Work environments and the people in them are continuously changing. For everyone’s safety, it is important to learn ways to assess all three elements of the Ongoing Interactive
Assessment at any given moment. In order to intervene before a situation becomes violent, you must be able to recognize early warning signs that the situation is escalating.

**Assessment of Self**

Reacting to a stressed or angry person by becoming stressed or angry yourself is always a lose–lose situation.

**Reactions**

**Tone of voice** – Do I sound defensive, uncaring, or mean?

**Body language** – Are my arms crossed? Am I making eye contact? Is my facial expression angry or calm?

**Personal space** – Am I standing too close or letting the other person get too close to me?

**Dangerous items** – Am I wearing or holding anything that could be used to harm me, like a tie, scarf, jewelry, stethoscope, or scissors?

**Hair** – Am I wearing my hair in a way that would make it easy to grab (i.e. ponytail, braid, etc.)?

Once you assess yourself and see how your actions affect the situation, you can make adjustments in your behavior to help improve the outcome of the situation.

Important strategies include:

- use a *calm* voice;
- keep your *distance* and maintain appropriate *personal space*;
- remove anything from your person that can be used as a *weapon* or can be grabbed by someone;
- capture *long hair* in clips or tuck *ponytails* down the back of clothing;
- maintain an *open* posture and *non–threatening* eye contact;
- pay attention to your "*gut feeling*" as an early *warning sign*; and
- remember that your ability to communicate effectively depends upon being in *control of yourself*.

**Assessment of Others**

A stressed or angry person may provide clues to his or her experience or level of escalation.

**Reactions**

**Physical appearance** – Is hygiene or clothing neglected? Does the person appear fearful, anxious, threatened, hostile or suspicious?

**Personal behavior** – Is the person pacing, clenching fists, slamming doors, pushing things?

**Verbal behavior** – Is the person swearing, loud, exaggerating importance of self? Is the person using a threatening tone of voice?
Observation and Assessment

**Interpersonal behavior** – Is the person blaming others, not keeping good personal space, not responding to directions, or expressing intent to harm?

**Dangerous items** – Is the person carrying a weapon or appear to be hiding a weapon? Have you asked the person if they have any weapons today?

Once you've assessed the other person, you will have a better idea of the person's state of mind and what behavior to expect. Often violent behavior is preceded by signs that a person is feeling distressed or out of control.

Important strategies include:

- watch for changes in behavior;
- be aware of the person's verbal and non-verbal signs of increasing distress;
- assess for potential weapons;
- be comfortable asking a person if they have any weapons; and
- take seriously all threats to harm or act violently.

**Assessment of the Environment**

The environment in which you encounter someone also requires assessment.

**Heavy lamp:** Potential weapons – staplers, letter openers, paperweights, vases, coffee mugs?

**Chair:** Arrangement of furniture – difficult to reach door quickly?

**Door:** Available exits – only one, blocked by anything?

**Person in line:** Confusion/noise/overcrowding – too many people, potential “audience” for a disruptive situation?

**Thermostat:** Temperature of room – extreme?

**Clock:** Time of day/shift change – fewer available staff than usual?

An important part of decreasing the impact of violence is keeping your environment as safe as possible. Assess and modify your work areas on a regular basis to minimize risk.

Important strategies include:

- removing heavy or sharp objects that may be used as weapons;
- decreasing barriers or obstacles between you and any exits;
- not trying to stop an angry person from leaving an area;
- adjusting the temperature to accommodate the widest range of people;
- isolating the situation, not yourself, by removing bystanders and onlookers;
- suggesting relocating to a quieter area;
- being flexible about changing processes to meet the person’s needs;
- being aware of emergency phone numbers or where your panic button is located; and
- being aware that mealtimes, change of shift, transfer of individuals, and after-hours are times in which more disruptive behaviors may occur.

**Important**

Know and follow your facility’s policy regarding securing weapons.
Observation and Assessment: Summary

You have successfully completed the Prevention and Management of Disruptive Behavior: Observation and Assessment lesson. You should now be able to:

1. identify different levels of disruptive behavior;
2. identify causes of disruptive behavior that may lead to violence against an individual;
3. recognize strategies for prevention of a disruptive or violent incident;
4. associate the assessment triangle to its influence on the outcome of a situation; and
5. identify best practices for keeping your environment safe.
Predisposing and Precipitating Factors

Predisposing and Precipitating Factors: Introduction

This lesson provides insight into Predisposing and Precipitating Factors. In this lesson, you will learn to:

1. define predisposing factors;
2. define precipitating factors;
3. differentiate between predisposing and precipitating factors of behavior;
4. recognize strategies to minimize (mitigate, lessen) precipitating factors; and
5. associate predisposing and precipitating factors case scenarios.

Predisposing Factors: What Is Going On Inside A Person

Predisposing factors are unique, internal qualities or experiences that every person brings into a situation. Every person in the environment is affected by his or her own predisposing factors – including you!

There are many predisposing factors that can increase a person’s risk for becoming disruptive. The more of these predisposing factors a person has the greater the risk of violence. Select the individual characteristics for predisposing factor details.

Personality Traits

The following are personality trait factors:

- loner or withdrawn from others;
- problems getting along in or managing social situations;
- suspicious of others or blames others for problems;
- cannot handle frustration well;
- frequent or extreme mood swings;
- sees the world as hostile or threatening;
- feels trapped or like s/he has no options; and
- problems with authority figures.

History

The following are history factors:

- frequently fired from work or quits jobs out of anger;
- history of being violent in the past;
- history of being the victim of violence; and
- history of domestic violence or break down of family support system.

Personal Interests

The following are personal interest factors:

- obsession with violent music, games, movies, or activities;
- excessive interest in homicides or violent incidents;
- empathy for or identification with those who commit acts of violence; and
- obsession with weapons.
Health Problems

Note

Not all mentally ill people are violent, and not all violent people are mentally ill.

The following are health problem factors:

- chronic pain or terminal illnesses;
- feelings of hopelessness or like "I have nothing to lose;"
- mental illnesses that weaken decision making ability;
- brain injury or diseases that weaken decision making ability; and
- excessive drug or alcohol use or addiction.

Diversity in the Workplace

Our workplaces reflect our communities — we serve a wide range of people and we ourselves come from diverse backgrounds.

In dealing with each other, be aware that cultural values influence the way each one of us behaves and the kinds of predisposing factors we bring to each experience.

For example, cultural values can affect attire, hairstyle, body language, word choice, language, and even how respect is expressed. Sensitivity to these differences will promote a workplace at lower risk for disruptive behavior and greatly contribute to the environment of care.

Precipitating Factors: What is Going On Outside a Person

Precipitating factors are things in an environment or situation that can trigger a disruptive response.

Because they exist outside of people, you have the power to change precipitating factors in order to avoid disruptive situations.

Problems such as trouble parking, confusing directions, or bad weather may occur when people come to your workplace.

If you ignore a person’s irritation over these problems, you lose an opportunity to ease the pressure on the person. When you respond to the irritation with genuine empathy, you have a good chance of preventing potential escalation to violence.

Precipitating Factors in Any Customer Service Workplace

If you work with people in a customer care/service profession, many things about your workplace may be precipitating factors.

Environment: rain, snow, heat, cold, rude strangers

Staffing interaction: perceived lack of empathy, care or concern

Excessive noise: sounds that may not be offensive to most, such as music, may agitate others

Convenience of service: waiting times, confusion in waiting area, incompatibility with others who are waiting, being sent from place to place to receive service

Child in line: problems with spouse, child, parent, or other family member present
Prevention and Management of Disruptive Behavior

Predisposing and Precipitating Factors

**Outdated or inaccurate signage:** insufficient, difficult to read

**Disruption:** construction, organizational changes

**Traffic and parking:** inadequate parking, dangerous traffic flow

**Addressing Precipitating Factors**

While many precipitating factors may be out of your control, there are things you can do to make the impact of these factors on others less stressful.

Important strategies include:

- acknowledging and **showing empathy** for the frustration the person is feeling;
- reassuring the person that feeling stress over these issues is normal and offer alternatives whenever possible; and
- when possible, make changes that reduce frustration, such as reducing noise from TVs or radios, offering a less crowded place to wait, or walking a lost person to his/her appointment rather than giving long directions.

**Precipitating Factors in Medical Center Procedures**

If you work with people in a medical center, there will be even more things about your workplace that may be precipitating factors.

- **Pharmacy window:** lack of privacy, no private areas to discuss personal/confidential information, conduct physical exams
- **Person in waiting room:** loss of dignity, independence and control, right away the patient has to take off all their clothes and wear a gown or pajamas
- **Technician conferring with doctor:** loss of identity, co-workers refer to individuals by problems, diagnoses, room numbers
- **Exam room bed:** fear of pain, fear of what may occur during an exam, testing, surgery procedure
- **Digital readout of “Now serving #75”:** frustration, long waits

**Addressing Precipitating Factors in a Medical Center**

While many precipitating factors in medical centers may be out of your control, there are things you can do to make the impact of these factors on others less stressful.

Important strategies include:

- referring to people by name and not by their medical problem or number;
- taking time to talk with each person and explain what is happening; and
- making sure that you and others are treating each individual with dignity.

**Remember**

Think about how it feels to be that person, especially in a medical center setting.
Identifying Factors

The activity in this lesson is based on a short story. You will be asked to identify what the individual brought to the situation that predisposed them to disruptive behavior, and what the situation presents that acts as a trigger, precipitating potential escalation.

Predisposing and Precipitating Factors: Scenario 1

Kacey, a 42 year-old married woman, whose husband is deployed with the military overseas, cares for her two children and aging mother with no local family support. Earlier in the afternoon her 81-year-old mother received a compound fracture when she fell down the stairs and was admitted to the hospital. Kacey comes with her two children, ages 8 and 10, to visit her mother. The charge nurse informs Kacey that the two young children are not old enough to be on the unit. Kacey and the nurse argue. The two young children become increasingly disruptive. Kacey begins crying uncontrollably. The hospital chaplain arrives on the scene and Kacey turns to him for assistance. The charge nurse continues to maintain her position despite pleas from the chaplain.

Nurse: Sorry, You can’t have children here!

Kacey: (crying) We’re just here to see their grandmother!

Nurse: No children!

Chaplain: Excuse me, I’m the chaplain. Maybe I could help.

Nurse: Thank you, but the children are not allowed here!

Predisposing and Precipitating Factors: Scenario 2

Cameron, a 38 year-old patient who is on oxygen, has been rather unpredictable in the last several months and was recently diagnosed with terminal lung cancer. His birthday just passed and no one from his family came to visit. Cameron is told he is not able to go outside and smoke until the designated “smoke time.” Several hours later, feeling frustrated, he is finally able to go out and smoke. A maintenance person overhears him threatening to blow himself up.

Cameron: They won’t let you do a damn thing around here. I’m dying anyway; I’m just going to blow myself up!

Maintenance Person: Excuse me, I don’t know if he meant it, but I just heard something scary!

Predisposing and Precipitating Factors: Summary

You have successfully completed the Prevention and Management of Disruptive Behavior: Predisposing and Precipitating Factors lesson. You should now be able to:

1. define predisposing factors;
2. define precipitating factors;
3. differentiate between predisposing and precipitating factors of behavior;
4. recognize strategies to minimize (mitigate, lessen) precipitating factors; and
5. associate predisposing and precipitating factors case scenarios.
Stress Levels and Staff Intervention

Stress Levels and Staff Intervention: Introduction

This lesson provides insight into Stress Levels and Staff Intervention and understanding the five levels of stress. In this lesson, you will learn to:

1. differentiate between normal, moderate, severe, panic, and tension reduction levels of stress;
2. identify when staff intervention may be necessary to prevent disruptive behavior or violence;
3. distinguish various verbal and non-verbal intervention techniques; and
4. assess Veteran behaviors to identify the demonstrated stress level.

Levels of Stress: Description of Levels

Understanding the five levels of stress will increase your ability to assess yourself and another person in any potentially disruptive situation.

**Normal:** This level of stress is a part of day-to-day living.

**Moderate:** As stress increases, then our awareness of the environment around us decreases, becoming limited to the immediate task at hand.

**Severe:** Our awareness of the environment around us decreases even more as stress continues to increase.

**Panic:** This is the most intense and destructive level of stress.

**Tension Reduction:** During this phase stress decreases and returns to normal level of stress.

Someone with a high potential for disruptive behavior may experience these levels differently. For instance, stress may rise to panic level faster than you might expect, and stay there longer than with the average person.
Intensity of Levels of Stress

In describing what a person experiences at each level of stress, we talk about the "perceptual field." This is the area of things surrounding a person that can be experienced with the five senses (taste, smell, sound, vision, touch). These are also known as perceptions. So, the perceptual field is the space around us that we can perceive or sense.

Level of Stress: Normal

Normal stress, such as a work deadline, can sharpen the senses, increase motivation, and improve performance on routine activities. At this level of stress, we are the most alert and the perceptual field is actually larger than usual to improve functioning. At this stage, we see, hear, and grasp more things in our environment, allowing us to solve problems and learn effectively.

Level of Stress: Moderate

Moderate stress begins to reduce the perceptual field. In this state we are focused on the here and now and do not take in as much outside information. We may not even hear all of the information someone is telling us or showing us.

Level of Stress: Severe

At a severe level of stress the perceptual field becomes so small that it is like tunnel vision. We may only be able to focus on one thing, such as the person in front of us or the thing that has made us angry. Processing new or complex information is almost impossible. This is the level where people "shake with rage."

Level of Stress: Panic

At the panic level of stress, the perceptual field almost disappears and we can focus only on ourselves. We can no longer process any outside information. At this point, we are at high risk for violent behavior and becoming a threat to ourselves or others. Feelings of anger, fear, or helplessness may come out explosively in a "fight or flight" response. This is what people refer to as a "blind rage." Often people will not be able to remember what they said or did during this level of stress.

Level of Stress: Tension Reduction

During tension reduction, the perceptual field begins to return to normal. We can once again hear, see, and sense information in the environment around us. We are calming down and often people in this stage respond well to reassurance, encouragement, and calming responses from others around them.

It is important for caregivers to use this tension reduction phase to restore good relationships with the person who is calming down. Whenever possible, help the person to "save face" by reassuring the person instead of punishing or embarrassing the person further. The goal is to return to a normal level of stress and avoid returning to the panic level again.

Staff Intervention

Understanding the different levels of stress and their symptoms helps you to act early to prevent disruptive behavior or violence. The type of action you choose will depend, in part, on the patient’s stress level.
The goal is always to maintain a supportive connection with the patient. This includes matching the intensity of your response to the intensity of the patient's stress level.

<table>
<thead>
<tr>
<th>Stress Level</th>
<th>Staff Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Customer service</td>
</tr>
<tr>
<td>Moderate</td>
<td>Verbal and non-verbal de-escalation</td>
</tr>
<tr>
<td>Severe</td>
<td>Limit setting</td>
</tr>
<tr>
<td>Panic</td>
<td>Personal safety skills and/or therapeutic containment</td>
</tr>
<tr>
<td>Tension reduction</td>
<td>Therapeutic rapport</td>
</tr>
</tbody>
</table>

**Non-Verbal Interventions**

The single most important non-verbal communication you can convey is empathy.

Empathy is the act of connecting with the feelings or thoughts of others, usually in a genuine, warm, and caring way. Empathy allows an individual to feel heard and understood. It can be very effective in de-escalating (calming down) a potential crisis. If your usual attitude is not one of empathy, trying to express it during a crisis may be very difficult.

Showing empathy can sometimes be difficult. There are several important non-verbal communications we send to people that show empathy and can help an angry person calm down or de-escalate.

Key strategies include:

- remain calm and in control of your emotions;
- keep eye contact and open body language (no crossed arms);
- keep hands open and visible;
- use active listening; nod your head to show you are paying attention;
- respect personal space, staying at arm/leg-length away (out of striking distance);
- avoid touching an angry patient because it may be misinterpreted;
- show confidence in your ability to resolve the situation;
- avoid threatening gestures, such as finger pointing;
- avoid laughing or smiling inappropriately; and
- approach an angry person from the side or at an angle, since approaching head-on can appear confrontational.

**Verbal Interventions**

Combined with non-verbal communications that show empathy, your words can change a potentially disruptive situation, leading to reduced stress and safety for all concerned. Here are a few examples:

**Giving recognition:** Good Morning, Mr. Thompson.

**Offering self:** I’ll sit with you awhile.

**Asking open-ended questions:** And then? Tell me about it.

**Making observations:** You appear tense. I notice that you are biting your lips.
Restating: Patient: I can’t sleep. I stay awake all night. Nurse: You have difficulty sleeping.

Giving information: Mr. Jones, I’m here to explain the procedure you’re about to experience.

Seeking clarification: What is the main thing you would like accomplished?

Presenting reality: I see no one else in the room. That sound was a car backfiring.

**Other Helpful De-escalation Techniques**

When someone is at a moderate level of stress, sometimes suggesting an alternative activity may help de-escalate the situation and provide more opportunities for non-verbal and/or verbal interventions.

Examples of alternative activities include:

- going for a walk;
- working out in the gym;
- offering a cold beverage;
- turning on some music;
- guided relaxation/visualization;
- moving to a designated "Quiet Room"; and
- taking a medication that is prescribed for the person when he or she becomes angry or anxious.

It is important to be cautious about alternatives you provide. For instance:

- do not offer hot beverages that may be thrown on you in anger;
- music that relaxes one patient may anger or upset another; and
- the use of a punching bag may actually escalate the stress.

**Limit Setting**

When people rise to a severe level of stress, setting limits can place external control on the situation and give them useful ways to regain control of themselves.

**What to Do to Set Limits Effectively**

- Do use very short and simple sentences.
- Do remain calm, polite, and respectful.
- Do describe the behavior you want to happen instead of the behavior you want to stop.
- Do describe realistic consequences if behavior does not stop only when other limit setting techniques fail.

**What Not to Do When Setting Limits**

- Do not get into a power struggle or feel like you have to "win."
- Do not make threats.
- Do not make promises you cannot keep.
- Do not use consequences that you cannot enforce.
- Do not raise your voice.
It is common to confuse limit setting with threats. The key difference is that limit setting should help calm a patient by showing him/her how to regain control, whereas threats usually cause a patient to feel even more out of control and likely to become violent.

**Examples of Limit Setting**

Limit setting techniques can be very effective in helping people calm down and regain control. The chart below shows examples of good limit setting techniques on the left compared to threatening or bad techniques on the right.

<table>
<thead>
<tr>
<th>Good Limit Setting Techniques</th>
<th>Bad Techniques or Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Please, lower your voice.&quot;</td>
<td>&quot;Stop yelling at me.&quot;</td>
</tr>
<tr>
<td>&quot;I can help you if you have a seat, please.&quot;</td>
<td>&quot;You need to sit down or I’m not going to help you at all.&quot;</td>
</tr>
<tr>
<td>&quot;Please, move back or I’ll call for help.&quot;</td>
<td>&quot;If you don’t back off, I’ll have you arrested!&quot;</td>
</tr>
<tr>
<td>&quot;Please, call me by my name.&quot;</td>
<td>&quot;Call me that name again and I will ban you from the hospital.&quot;</td>
</tr>
</tbody>
</table>

**Analyzing Stress Levels: Introduction**

The activity in this lesson based on a series of short video clips. You will be asked to analyze the behavior you see. Given the health information of the patient combined with the verbal and non–verbal cues that you observe in the video, identify the level of stress portrayed and the most appropriate type of staff intervention.

**Analyzing Stress Levels: Scenario**

**Scenario 1**

Martin is 62-years-old with a history of drug-seeking behavior. He has serious injuries from a motorcycle accident and a legitimate prescription for pain medications. Several years ago, Martin was arrested for trading prescription medications for illegal street drugs. He comes to his primary care clinic without an appointment demanding another prescription for his pain medications. He tells the clerk he requested a 60-day supply but received only a 30-day supply. Martin is informed that his primary care physician is unable to see him that day. He leaves the clinic.

**Martin:** I need a new prescription. They gave me pills for thirty days and I need sixty.

**Clerk:** Do you have an appointment?

**Martin:** No.

**Clerk:** Just a minute, please, let me see what I can do.

Based on this scenario, answer the following questions.

1. What level of stress is Martin expressing?
   A. Panic
   B. Normal
   C. Moderate
Feedback: Martin’s voice (edgy tone), his body language (intense striding at a slightly quicker than necessary pace) as he approaches the desk, and his facial expressions (furrowed brows expressing frustration) all suggest that he has escalated beyond a normal level of stress.

1. If you were the clerk in this situation, what type of intervention would you choose as appropriate to the level of Martin’s stress?
   A. A Verbal and Non-Verbal
   B. Limit Setting
   C. Customer Service

Feedback: Although Martin’s signs of escalation are subtle at this time, they are present. Addressing his moderate stress level with appropriate verbal and non-verbal interventions has the potential to de-escalate the situation, leading to a positive outcome.

Scenario 2

Martin is 62-years-old with a history of drug-seeking behavior. He has serious injuries from a motorcycle accident and a legitimate prescription for pain medications. Several years ago, Martin was arrested for trading prescription medications for illegal street drugs. He comes to his primary care clinic without an appointment demanding another prescription for his pain medications. He tells the clerk he requested a 60-day supply but received only a 30-day supply. Martin is informed that his primary care physician is unable to see him that day. He leaves the clinic and goes to see the medical center director, and then the patient advocate.

Clerk: I’m sorry; the doctor can’t see you today.

Martin: (angrily) Great!

Director: I’m sorry I can’t help you. Could I take you to see the patient advocate?

Patient: You know what? I can’t believe this.

Advocate: (trying to be helpful) Have you tried Mental Health?

Martin: (turning away angrily) What kind of B.S. is that?!!!

1. What level of stress is Martin expressing? Severe
   A. Normal
   B. Moderate

Feedback: Based on Martin’s behavior of yelling at staff, shoving papers off the desk, and abruptly exiting the office it appears that he has escalated to a severe level of stress.

2. If you saw this situation occurring and realized you could intervene, what type of intervention would you choose as most appropriate to the level of Martin’s stress?
   A. Verbal and Non-Verbal
   B. Limit Setting
   C. Personal Safety Skills and/or Therapeutic Containment

Feedback: Behavioral limits are set directly with individuals. In this scenario, Martin left the office and may not pose a direct threat to the patient advocate’s safety, but he remains at a severe level of stress. He is likely to encounter other staff in the medical center. Because the situation seems volatile, you should know your facility’s procedures for notifying the appropriate authorities who can intervene to set limits to protect the individual’s safety and the safety of others.
Scenario 3

Martin is 62-years-old with a history of drug-seeking behavior. He has serious injuries from a motorcycle accident and a legitimate prescription for pain medications. Several years ago, Martin was arrested for trading prescription medications for illegal street drugs. He comes to his primary care clinic without an appointment demanding another prescription for his pain medications. He tells the clerk he requested a 60-day supply but received only a 30-day supply. Martin is informed that his primary care physician is unable to see him that day. He leaves the clinic and goes to see the medical center director, then the patient advocate, and finally, Mental Health.

Receptionist: Actually, it looks like none of the therapists will be able to see you for about two weeks.

Martin: Really? Well, see if they can see this!

Based on this scenario, answer the following questions.

1. What level of stress is Martin expressing?
   A. Panic
   B. Normal
   C. Severe

   Feedback: Picking up a chair and using it as a weapon against staff is a clear indicator that the patient's previously severe level of stress has escalated to panic level. His behavior suggests that the "fight" aspect of his "fight, flight, or freeze response" to stress has been activated.

2. At a panic level of stress, what type of intervention would you choose?
   A. Verbal and Non–Verbal
   B. Limit Setting
   C. Personal Safety Skills and/or Therapeutic Containment

   Feedback: Once someone's behavior escalates to panic level, like Martin's has, you should take steps to protect yourself and others. Personal Safety Skills can help you protect yourself and escape the situation. If Martin discards or throws the chair and is no longer armed with the chair as a weapon, you can use Therapeutic Containment to contain Martin until his behavior is safe again. You should know your facility's policy for use of Therapeutic Containment and notification of VA Police, Behavioral Code Team, or security.

The correct answers are:
Scenario 1 — 1=C, 2=A
Scenario 2 — 1=A, 2=B
Scenario 3 — 1=A, 2=C

Stress Levels and Staff Intervention: Summary

You have successfully completed the Prevention and Management of Disruptive Behavior: Stress Levels and Staff Intervention lesson. You should now be able to:

1. differentiate between normal, moderate, severe, panic, signs of tension reduction, and levels of stress;
2. identify when staff intervention may be necessary to prevent disruptive behavior or violence;
3. distinguish various verbal and non-verbal intervention techniques; and
4. assess Veteran behaviors to identify the demonstrated stress level.
Patient Record Flags

Patient Record Flags: Introduction

This lesson provides insight into Patient Record Flags and violence prevention. In this lesson, you will learn to:

1. define Patient Record Flags;
2. identify the purpose for placement of patient record flags;
3. recognize how violence can be reduced by using Patient Record Flags; and
4. define the role of the Disruptive Behavior Committee (DBC).

Introduction and Background

So why do we need training in violence prevention?

- Healthcare workers have the highest rates of non–fatal injury from workplace assaults of any occupational group.
- In 2001, over 12% of VHA employees and over 25% of VHA nurses experienced at least one assault.

To address these hazards, VHA:

- regularly updates the Prevention and Management of Disruptive Behavior (PMDB) program;
- implements findings from Network Director Performance Monitors on violence prevention; and
- develops new materials on threat assessment and management.

Violence prevention in healthcare is mandated by both the Occupational Safety and Health Administration (OSHA) and The Joint Commission (TJC).

Development of Patient Record Flags

In order to help prevent violence in VHA, the VA Office of the Inspector General (OIG) recommends that facilities communicate among themselves regarding patients at high risk for violence.

National (or Category I) Patient Record Flags were developed to identify high-risk patients and communicate this risk to care providers regardless of where in the VHA system the patients seek healthcare. VHA Directive 2010–053 "National Patient Record Flags" governs the appropriate use of patient record flags.

VHA Use of Patient Record Flags

Benefits of Patient Record Flags

The VHA uses patient record flags to help support a safe work environment.

Category I Patient Record Flags

The purpose of Category I Patient Record Flags (PRFs) is to:

- alert staff within moments of opening a record that a patient has a potential for violence; and
- provide clear instructions on appropriate actions to be taken with the patient.
Placement of Patient Record Flags

Placement of PRFs reduces the risk of violence from patients by:

- assessing for a history of violence;
- documenting a history of violence;
- communicating a history of violence; and
- providing appropriate responses in engaging a person with a history of violence.

Common Triggers

Examples of events that commonly trigger the placement of behavioral patient record flags are:

- assaulting staff or other patients;
- documented acts of repeated violent behaviors;
- convincing or credible verbal threats of harm; and
- possession of weapons or objects used as weapons.

Disruptive Behavior Committee

The group responsible for managing Patient Record Flags (PRFs) is the Disruptive Behavior Committee (DBC), mandated at each facility.

The DBC:

- reviews assaults and incidents of violence or disruption;
- conducts workplace behavioral risk assessments; and
- enters and performs regular reviews of Category I PRFs.

The DBC is a multidisciplinary group made up of representatives from mental health, safety, security, VA Police and other disciplines at high risk for violence such as nursing, primary care and emergency department staff. The committee reports to the Chief of Staff (COS), and is chaired by the COS or a senior clinical leader.

You can contact the Chair of your DBC to find out how to make reports of violent or disruptive incidents at your facility.

Example of a Patient Record Flag (PRF)

A Category 1 PRF appears automatically when a patient record is selected in CPRS. A PRF can also be accessed by clicking on the "FLAG" button at the top of the window.

Patient Record Flags: Summary

You have successfully completed the Prevention and Management of Disruptive Behavior: Patient Record Flags lesson. You should now be able to:

1. define Patient Record Flags;
2. identify the purpose for placement of patient record flags;
3. recognize how violence can be reduced by using Patient Record Flags; and
4. define the role of the Disruptive Behavior Committee (DBC).
Sexual Assault Prevention

Sexual Assault Prevention: Introduction

This lesson provides insight into Sexual Assault awareness, prevention and reporting. In this lesson, you will learn to:

1. define sexual assault;
2. identify situations involving sexual assault;
3. recognize the methods used in sexual assaults; and
4. identify prevention and reporting strategies.

What is Sexual Assault?

There are many kinds of assaults reported in VA. One particular type of assault that employees may find difficult to understand or respond to is sexual assault. VA defines sexual assault as:

Any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity.

Sexual Assault Incidents

In June 2011, the Government Accountability Office (GAO) testified to Congress about their investigation of sexual assault on VA property.

The incidents investigated, listed in order of frequency of report, were:

1. inappropriate touch;
2. rape;
3. forced oral sex;
4. forced medical exam; and
5. exhibitionism, sexual letters, and molestation.

Who was Involved?

According to the GAO Report (GAO–11–736T):

- most cases involved patient perpetrators;
- some cases involved employee–on–patient assaults; and
- a smaller number of cases involved employee–on–employee assaults.

All but one of the patient perpetrators were men and all of the employee perpetrators were men.

It is important to remember, however, that both men and women can become victims of sexual assault.

Methods Used in Sexual Assaults

Methods of Manipulation

Perpetrators of sexual assault may use several methods to get their victims to participate in unwanted sexual activity.
Psychological Coercion

Using threats, fear of bad consequences, or promises of favors in return for the victim’s cooperation.

Some examples of psychological coercion include a:

- supervisor threatening to fire you if you do not perform oral sex;
- co-worker who promises not to report your medical error to the supervisor or hospital administration in exchange for sex; and
- hospital contracting agent who promises to sign off on your government contract in exchange for sexual favors.

Physical Force

Using physical strength, weapons, or the threat of physical harm to overpower a victim.

Some examples of physical force include:

- holding a knife to someone's throat;
- physically holding someone down; and
- threatening to shoot someone.

Sexual assaults may also involve victims that temporarily or permanently lack the ability to understand or consent to sexual activity.

Perpetrators often target such victims specifically because they do not have capacity to consent to sexual activity and this makes them vulnerable to assault.

Capacity to consent means an individual's ability to understand a situation and to make an informed, voluntary decision to participate or not participate in an activity.

Some people are more likely to lack capacity to consent. Examples include people:

- with severe psychiatric illnesses like dementia, schizophrenia, mania, or psychosis;
- with developmental disorders like mental retardation; and
- under the influence of alcohol or drugs, including medical sedation.

Also, even when a person has capacity to consent, he or she may have a condition that interferes with the ability to voice agreement or refusal of sexual activity, such as people with injuries that interfere with speech and language.

Levels of Behavior

Recognizing dangerous behavior early and taking action sooner rather than later is very important for violence prevention.

Research into sexual assault shows that some perpetrators groom their targeted victims by committing "low level" offenses to see whether a red light (stop) or green light (go) is given by the potential victim.

If low–level behavior is allowed or ignored (green light), then the perpetrator moves to increasingly more unacceptable behavior to test the victim’s response to possible "high level" offenses.
Prevention and Management of Disruptive Behavior

Sexual Assault Prevention

If a targeted victim shows an assertive negative response to a slight offense (red light), the perpetrator realizes that they will need to continue searching to find a more vulnerable target.

**Low Level Behavior**
- Inappropriate Staring
- Invasion of Personal Space
- Sexually Inappropriate Comment or “Joke”

**High Level Behavior**
- Unwanted Sexual Touch
- Sexual Assault, Rape
- Exhibitionism

**Green Light (Go!)**
- Jane looks away and says nothing when she notices John staring at her several times throughout the day.
- Bob laughs uncomfortably but doesn’t object when Doug tells a sexually explicit joke about two men in the locker room.
- Even though it makes him uncomfortable, Gary doesn’t want to cause problems by telling Sharon to stop rubbing his shoulders.

**Red light (Stop!)**
- Without looking away, Jane says to John, "Why are you staring at me? That makes me uncomfortable. Please stop."
- Bob tells Doug, "I don’t find jokes like that very funny. Please don’t share them with me anymore."
- Gary says, "Sharon, you may be trying to be nice, but please don’t rub my shoulders. It makes me uncomfortable."

**VA Prevention Strategies**

Now that we recognize predatory sexual behaviors, VA recommends Administrative and Individual strategies for prevention. When applied by everyone, these strategies help create a culture of non-violence that can lead to a safer environment for Veterans, staff, and visitors.

**Administrative Policy**

Physical, Sexual and Emotional Violence is totally and completely **unacceptable**.

Facilities are required by OSHA to have written violent behavior prevention policies and to implement violence prevention programs.

**Reporting**

Reporting is mandated and important for identifying the scope of the issue.

Any assault can be reported to VA Police and sexual assaults must be reported immediately.

Any incident involving a patient should be documented in a Patient Incident Report.
Prevention and Management of Disruptive Behavior

Sexual Assault Prevention

All disruptive or violent behavior should be reported to your Disruptive Behavior Committee (DBC).

Avoid Isolation
Perpetrators usually rely on isolating their victims.
Stay away from isolated environments.
Use a “Buddy System” on rounds.

Refuse Relocation
Perpetrators will often transport victims to isolate them or remove them from "the last place they were seen."
Risk of serious injury rises when offenders succeed at relocating victims to more isolated areas.
Do everything possible to avoid being physically moved from one location to another by the perpetrator.

Leave
Your "gut" feeling will often warn you when a situation does not feel or appear safe—Listen to that feeling.
If your instincts tell you a situation does not seem "right" or feels “unsafe,” leave the situation immediately.

Reporting as a Prevention Strategy
Consider the following scenarios:

Nancy is a patient in a residential unit where Lisa, one of the CNAs on the night shift, has been paying her increasing amounts of attention. One evening, Lisa corners Nancy at the end of an empty hallway and asks, "hey, do you know how sex is like riding a bicycle?" Nancy answers, "I don't really think dirty jokes are funny. So please don't tell me anymore."

After listening to Mr. Johnson's lung sounds, Dr. Michaels turns away to pick up a blood pressure cuff. As she does, Mr. Johnson squeezes her buttocks and says, "now it's my turn to check you out."

After their first day working together, Jake leans in close to Jill with his face almost touching her hair, takes a deep breath, and says, "I really love the smell of your shampoo." This makes her very uncomfortable and she asks him to not get so close to her.

Why Reporting is Important
By reporting these events, Nancy, Dr. Michaels and Jill can start a process that lets the:

- offender know his behavior is not okay, should stop immediately, and should never occur again;
- Disruptive Behavior Committee monitor behavior over time to see if this individual has a pattern of bad behavior that requires more serious action; and/or
- hospitals know that things like this are happening so they can put "safeguards" in place to protect employees and other patients from being assaulted as well.
Without reports, we would never find out that problems exist.

**What Sexual Behaviors Should You Report?**

The term "sexual assault" often brings to mind a man using force to have unwanted genital sex with a woman. The truth is that both perpetrators and victims of sexual assault can be male or female and sexual assault can involve many different types of unwanted sexual behavior.

The different kinds of sexual assault to be reported include:
- forced oral, genital or anal penetration “Rape”;
- forced penetration with an object;
- attempted rape;
- fondling;
- inappropriate or unwanted touch; or
- threats of rape.

There are often "gray areas" that are hard to define between one type of sexual assault and another.

Trust your gut instinct. An event may be hard to define as fitting into a particular category of sexual assault, but we know when something isn't right. **Report any sexual event that your instincts tell you isn't right.**

**How to Report Sexual Assault**

When it comes to sexual assault allegations, **VA Police must be notified immediately.**

It is mandatory that VA Police notify the Integrated Operation Center (IOC) **within two hours** of any allegations of sexual assault. If you are aware of, or suspect that a sexual assault has occurred (on VA property or anytime VA care is being provided in the community), your role is to:
- listen and be supportive;
- contact your supervisor or other management official; and
- contact VA police.

You are **not** responsible for deciding whether a sexual assault occurred.

**Sexual Assault: VA Stance**

VA treats sexual assault with the utmost seriousness and respect. Top priority is given to the care and support of the alleged victim, and to a thorough investigation of all allegations of sexual assault. Anyone suspected of committing sexual assault may be prosecuted to the full extent of the law.

**Sexual Assault Prevention: Summary**

You have successfully completed the Prevention and Management of Disruptive Behavior: Sexual Assault Prevention lesson. You should now be able to:

1. define sexual assault;
2. identify situations involving sexual assault;
3. recognize the methods used in sexual assaults; and
4. identify prevention and reporting strategies.
Law Enforcement and Violence Prevention

Law Enforcement and Violence Prevention: Introduction

This lesson provides information on the role of Law Enforcement in Violence Prevention. In this lesson you will learn to:

1. identify the VA Office of Security and Law Enforcement Mission and Vision;
2. understand the role of VA Police in workplace violence prevention;
3. understand how VA Police roles and responsibilities differ from other employees’ roles and responsibilities; and
4. identify successful ways to work with police in the workplace setting.

Mission and Vision

The Office of Security and Law Enforcement (OS&LE) is composed of two units: Police Services and the VA Law Enforcement Training Center (LETC).

Their mission is to "deliver professional law enforcement and security services, while maintaining law and order, and the protection of persons and property on VA campuses and buildings under the jurisdiction of the Department of Veterans Affairs."

The OS&LE vision is "to provide 21st century world class police services and operations that most effectively serve VA beneficiaries, employees, and visitors while functioning as a critical and indispensable part of the corporate VA team."

Role of VA Police in Workplace Violence Prevention

Every VHA Facility has a VA Police Service equipped to respond to emergencies and criminal activity. The VA police are highly valued allies and resources in creating and maintaining safe workplaces through interdisciplinary partnerships and collaboration, as well as enforcement of the law.

Common ways VA Police engage in prevention of workplace violence:

- participating as members of interdisciplinary Disruptive Behavior Committees and contributing to the development of guidelines for addressing workplace violence;
- providing knowledgeable application of state, local, and federal laws in workplace law enforcement;
- maintaining collaborative relationships with customers and employees that support the safety of all;
- investigating reports of violent, illegal, or disruptive behavior;
- responding to emergency calls from employees, patients, and others within the facility, and
- providing around-the-clock police presence in medical centers to deter criminal activity and disruption of VHA facility operations.
VA Police Assistance

The first duty of a law enforcement officer is to uphold the law and to know where legal boundaries are. Because officers represent the legal will of the community they serve (local, state, or federal) they must be aware of the limits of their own authority.

When working together, VHA employees sometimes disagree with the action or non-action of VA Police officers. This is often because the employees do not understand the legal limitations involved.

In this section, we will review the following common areas of concern when it comes to what VA Police can and cannot do when assisting VHA staff:

- Search
- Detention and Restraint
- Use of Force

Search

When patients come into emergency departments, inpatient units, residential units or community living centers, the staff of those programs have standard operating procedures for searching the patients and their belongings for contraband.

Contraband is any object that is not allowed in the hospital. These may be illegal things (i.e. street drugs, someone else's pain medications) or things the patient owns legally (knives, razors, alcohol, guns, etc.), but which are not appropriate for the patient to have while receiving care in the facility.

Problems with searches arise when the medical staff asks police to help with searches for contraband. The medical staff may not realize that the police do not have the same roles and purposes during searches that medical staff have.

Performing a Search: Differing Roles, Responsibilities, and Restrictions

Medical Staff Roles

During searches, the hospital staff has two purposes:

1. find contraband brought into the medical setting; and
2. remove contraband from the medical setting.

The role of the medical staff is to provide medical care. Clinicians do not have the right or responsibility of arresting people. This is why medical staff may not consider the issues of arrest or prosecution as an outcome of searches if illegal items are discovered. They are focused only on removing the contraband so that medical care can continue safely.
Police Roles

Police share the goal of keeping the medical center safe. They also have additional legal responsibilities, up to and including arrest, if they find evidence of illegal activity.

The Fourth Amendment of the United States Constitution protects people from unreasonable search and seizure by law enforcement. This amendment requires that police officers must have a judicially sanctioned warrant (i.e. search warrant) supported by probable cause before performing a search of a person or the person’s property with the following limited exceptions:

- consent of the person to be searched;
- search that occurs after the person is placed under arrest;
- search that includes any illegal items in plain view or visible to the Officer;
- frisking, or patting down of outer garments if an Officer has reasonable suspicion that criminal activity or weapons are present; and
- in situations of police emergencies, which usually wouldn't involve medical staff or care.

Resolution of Roles

Medical Staff and Police have very different roles, responsibilities, and legal restrictions when it comes to performing searches.

Having the police as well as legal counsel involved in writing standard operating procedures for searches in your workplace will help you to understand what the police can and cannot do to help you.

Detention and Restraint

We reviewed earlier in this training how sometimes a person’s medical condition can interfere with our ability to help. For instance, a person with dementia may not be able to follow directions for taking his medications or finding the radiology department.

Sometimes, a person may become so confused, sick, or agitated that in order to provide medical care we have to hold the person in the hospital against his/her will. One term for this is an "involuntary hold." The person’s agitation may become so severe that physical restraints must be used to hold the person in bed to prevent harm to self or others.

These actions restrict an individual’s freedom; therefore, they are governed by local, state, and federal laws stating who can make decisions about involuntary holds and restraints, as well as what the limitations are regarding that power.
Detention and Restraint of Patients: Roles and Responsibilities

Medical Staff Roles

The purpose of detaining a patient in a hospital or putting a patient in restraints is always to ensure that medical care can be given safely to the patient. Laws about involuntary holds and use of restraints can vary from state to state. Most laws will require that a medical professional examine the patient and make a medical statement that the patient is sick and must be held against his/her will in order to protect the patient’s safety.

The end goal is always medical care and treatment.

Police Roles

Remember the Fourth Amendment, which protects against unreasonable search and seizure.

Seizure is when a law enforcement officer restricts the freedom of an individual by holding the person against his will. Usually seizure is also known as an arrest. However, in cases of involuntary holds, seizure may mean the officer is physically bringing the person into the hospital against his will to get treatment or keeps the patient from leaving the hospital.

Just like searches, the Fourth Amendment requires police to work under the legal authority of the judicial system when performing seizures. The police cannot detain a free individual except as allowed by law (i.e. arrest warrant, commitment orders, etc.). Therefore, appropriate medical legal documentation, consistent with statutory law, must be in place for VA Police to assist medical staff in the process of involuntary hospitalization.

Resolution of Roles

Medical Staff and Police have very different roles, responsibilities, and legal restrictions when it comes to detention and restraint of a patient.

Having the police as well as legal counsel involved in writing standard operating procedures for involuntary holds and use of restraint in your workplace will help you to understand what the police can and cannot do to help you.

Use of Force

You have learned that behavior can appear along a spectrum ranging from mildly upset to dangerously violent. The responses of employees, medical staff, and police officers are also different along that spectrum.

In the Venn Diagram as shown, the left circle represents behaviors that the medical staff may safely address. The right circle represents behaviors that the police have a different set of skills designed to address. In the area where the circles overlap, the techniques used by medical staff and police may appear very similar. But beyond that area of overlap, when
behavior becomes so violent that lives are in danger, police may be required to use levels of force that prevent the continuation of care.

Addressing the Spectrum of Behaviors by Role

Medical Staff Roles

Most often, employees and medical staff work in the part of the spectrum in which patients can still be managed in a way that medical care can continue. This range begins with the patient actively participating in care and progresses to the point where the patient is so violent that restraints must be used for care to continue.

All along that spectrum, the employees and medical staff use verbal de-escalation techniques, personal safety skills, and therapeutic containment techniques taught in Prevention and Management of Disruptive Behavior (PMDB) classes.

The end goal is always medical care and treatment.

Police Roles

Police Officers are experts in a different range of the spectrum. Their role begins when the patient begins to act in a way that threatens safety and progresses to the far end of deadly violence.

Police have a duty to protect the safety of the public "through the legitimized use of force." This means that police have the legal authority to use whatever amount of effort is necessary to get an unwilling person to stop dangerous or illegal behavior and obey the law. Police may use levels of force ranging from verbal redirection and physical restraint on one
end of the spectrum to use of pepper spray and lethal force on the other end. (National Institute of Justice, Office of Justice Programs)

The end goals of police are to protect the safety of the public and enforce social order.

**Police Roles**

Medical Staff and Police have very different roles, responsibilities, and legal restrictions when it comes to techniques they use to redirect disruptive or violent behavior.

Having the police as well as legal counsel involved in writing standard operating procedures will help you to understand what the police can and cannot do to help you.

**Responsibility to Provide Care**

It is important to remember that the availability of a trained and effective VA Police Service does not lessen the need for employees involved in direct patient care to manage disruptive patient behavior responsibly and effectively. The VA Police are ready to ensure that no employee is subjected needlessly to physical abuse or bodily harm. However, patient care staff must also know how to manage disruptive behavior, up to and including use of restraints, without depending on police as a tool of disciplinary or coercive force in patient care management.

**Working Appropriately with VA Police**

When it comes to working together, there are appropriate ways to interact with Law Enforcement and inappropriate ways.

**Appropriate Interactions with Police**

VA Police are law enforcement professionals with extensive education and experience unlike any other group of professionals in the healthcare workplace.

Some examples of appropriate ways to interact with Law Enforcement professionals include:

- fully cooperating with police investigations, orders, and/or instructions;
- remaining calm, attentive, professional, and polite when talking with police;
- providing thorough, factual information regarding emergencies or incidents of disruptive, violent, or illegal behavior;
- getting out of the way when police determine higher levels of force are required;
- respecting the authority and expertise of our Law Enforcement co–workers; and
- debriefing with police after an incident to lessen confusion over actions taken during the incident.
Inappropriate Interactions with Police

Some examples of ways that are not appropriate to interact with VA Police include:

- asking police to force a patient to be compliant with medical interventions, medications, or treatment plans;
- giving orders to or making demands of police officers;
- making sudden movement toward an officer, or the officer’s belt or other equipment; and
- interfering with or attempting to prevent an officer from performing legal duties or using force to protect the public.

Law Enforcement and Violence Prevention: Summary

You have successfully completed the Prevention and Management of Disruptive Behavior: Law Enforcement and Violence Prevention lesson. You should now be able to:

1. identify the VA Office of Security and Law Enforcement Mission and Vision;
2. understand the role of VA Police in workplace violence prevention;
3. understand how VA Police roles and responsibilities differ from other employees’ roles and responsibilities; and
4. identify successful ways to work with police in the workplace setting.
End of Course

Prevention and Management of Disruptive Behavior - Course Summary

Congratulations, you have completed the content review for the United States Department of Veterans Affairs course titled: Prevention and Management of Disruptive Behavior. To receive credit for this course, you must complete each required lesson and pass the assessment at the end of each lesson.
Help

Contact Us

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