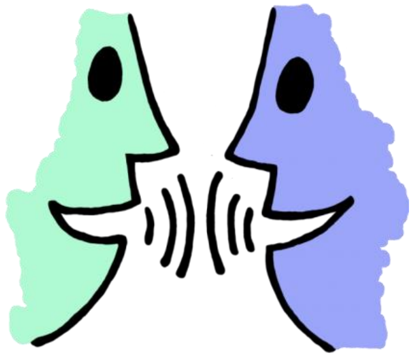
Management of Risky Inpatient Behavior:
Approach to management when patient choices cause high stakes



Update in Internal Medicine
October 20, 2023

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Why must we discuss this topic?

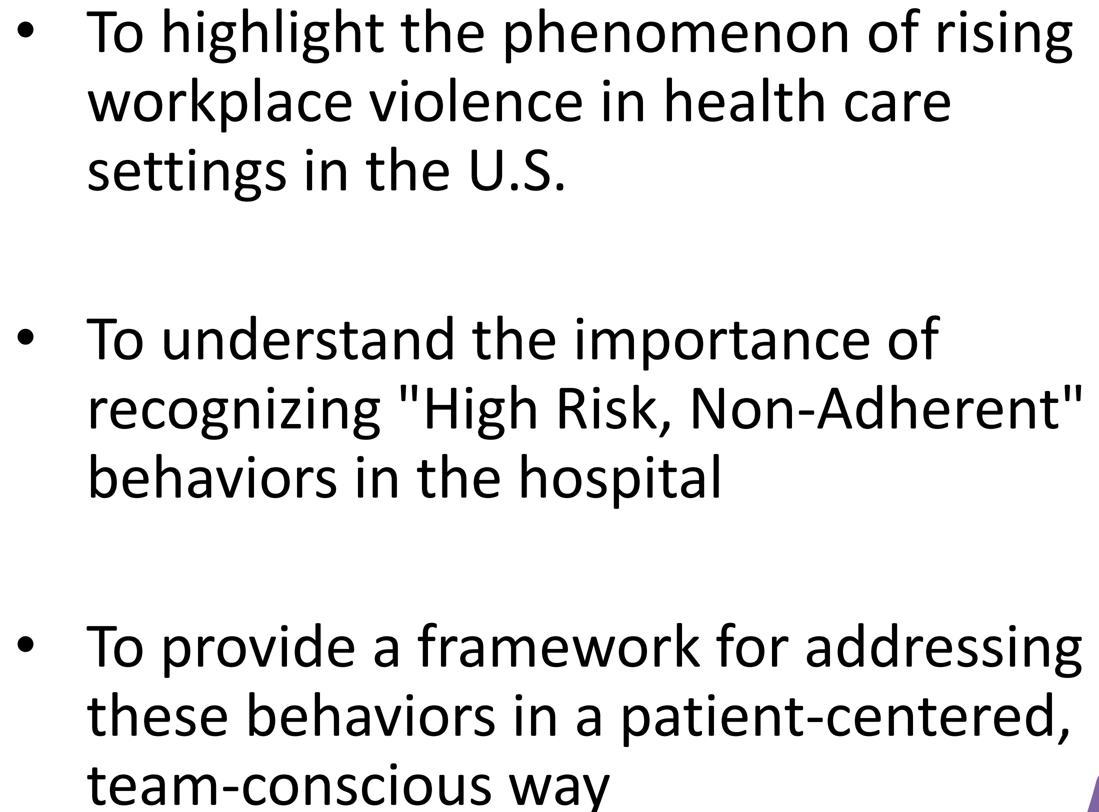
The hospital is a unique environment in which many disciplines must unite in the care of acutely ill patients

Pressures on physicians, APPs, and nurses to provide efficient, cost-effective care while supporting an excellent patient experience are immense

Patients' and families' expectations of the setting, content, and duration of our care can be misaligned with our recommendations

Conflict among any of these players can result in catastrophic patient outcomes, provider angst and burnout, and sometimes even abusive or violent interactions

Our Goals Today



- To highlight the phenomenon of rising workplace violence in health care settings in the U.S.
- To understand the importance of recognizing "High Risk, Non-Adherent" behaviors in the hospital
- To provide a framework for addressing these behaviors in a patient-centered, team-conscious way

What are High Risk, Non-Adherent Behaviors?

Behaviors that disrupt the safety of our health-care environment

when demonstrated by a patient who has decision-making capacity

Examples of risky behaviors:

- Physically threatening health-care workers
- Use of offensive language
- Leaving the hospital campus
- Smoking in the hospital
- Use of non-prescribed substances without notifying team
- Tampering with IV access, pumps, or other equipment

The Principles

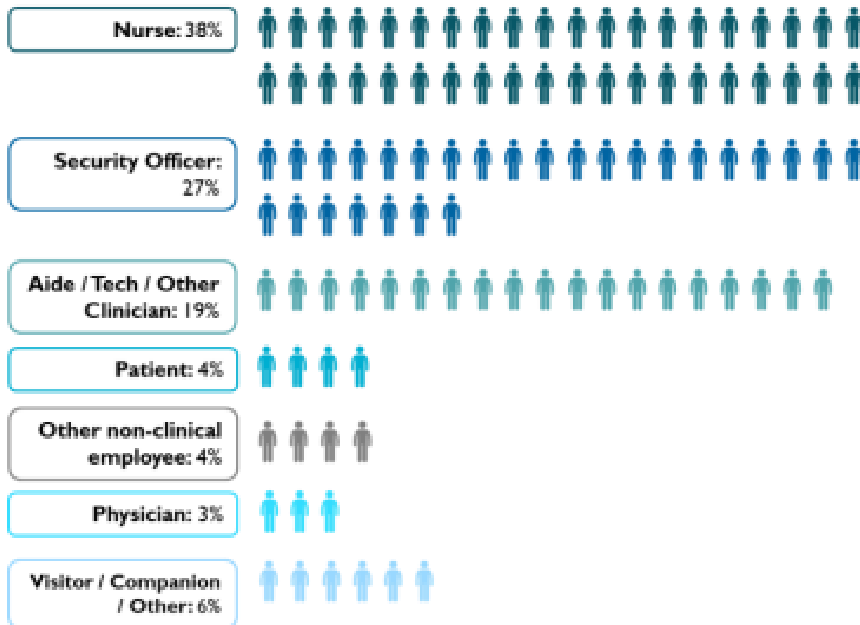
When a patient displays behavior that places themselves and/or others at significant risk, our aims are:

- To ensure safety of our staff and patients
- To ensure a consistent, timely, ethical process for addressing patients' needs
- To collaboratively determine risks & benefits of elements of medical care

You may have heard about this…

Violence in Massachusetts Healthcare Facilities: A Call to Action. Produced by Massachusetts Health & Hospital Association. January 2023.

And you may have heard about this…



Violence in Massachusetts Healthcare Facilities: A Call to Action. Produced by Massachusetts Health & Hospital Association. January 2023.

And earlier this year...

7 Henrico Deputies, 3 Hospital Employees Charged in Patient Restraint Death

The 28-year-old man was being transferred from a jail to a state-run mental health hospital when he died during the intake process.

March 2023

- Patient was in police custody for burglary accusation. At local hospital, patient was reported to have assaulted three officers.
- He was charged with assault on a law enforcement officer, disorderly conduct in a hospital, and vandalism.
- Three days later, when evaluated at a hospital, he became combative during the intake process and died while being restrained.
- Deputies and hospital employees charged with 2nd-degree murder

https://www.campussafetymagazine.com/hospital/henrico-deputies-hospital-employees-charged-in-patient-restraint-death/ -- Accessed 9/28/23

Addressing HRNA Behavior is Critically Important

Patient & Staff Safety

- ‘Usual’ (outpatient) behavior takes on added risk in inpatient setting. Examples:
  - High emotions + Unable to 'walk away'
  - Smoking (risky) + Next to oxygen
  - Illicit substance use (risky) + inpatient meds

Combat patient bias & stigma

- Team-based approach can ‘check’ the biases of individuals

Staff moral distress related to the harm caused our biases

Why is this so difficult to manage?

- High-risk situations bring out lots of emotions
- Causes of patient behavior is complex
  - Pain, SUD, Trauma, Mental Health, Stressors
- Expectations of Patient Behavior are often not explicit

Why is this so difficult to manage?

Wide range of **who is at risk**, and **to what degree**

- Nurses see & bear brunt of aggressive behavior
- Physicians ‘feel’ legal liability for discharge decisions and aim to advocate for preventing harm to vulnerable populations
- Patients endure worse pain, isolation, or substandard care if there is inconsistency or relationships breakdown

Each team members' risk assessment is based on their own biases & experiences

How to manage inpatient HRNA behavior?

1. Capacity? ☑
2. ‘Meet’ the patient
3. Gather your team
4. Specify risks to patient & others
5. What else can mitigate risk?
6. Patient-informed choice

Compassionate Boundaries

Compassionate Boundaries

Consistent (Agreement across team)

Reasons are Specific & Relevant to patient

Know when you can say, ‘Yes’

(and when you can’t)

Be willing & ready to accept that patient may choose not to adhere to boundaries…

In what settings are these tools *inappropriate*?

- Patients unable to understand their treatment plan and/or unable control behavior due to medical illness
  - Delirium, severe mental illness, cognitive impairment

Management of behavior hinges on our assessment of capacity to understand harms of their behavior, or benefits/risks of their medical illness

A Case: Inpatient High-Risk Behavior

Mr A: Presents with severe back pain, radiates to leg

- History of multiple spinal fusions, most recently L4-S1, as well as chronic back pain on chronic opioids
- Back pain in last 2-3 weeks is unlike any that he has had previously.
- Associated with fevers and chills
- MRI of lumbar spine shows phlegmon concerning for abscess
- Blood cultures reveal staph bacteremia
- With treatment with IV and PO opioids, Mr A continues to have severe flares of pain

A Case: Inpatient High-Risk Behavior

Mr A: Admitted with spinal abscess and bacteremia

- After surgical I&D, in next few days post-op, Mr A often raises his voice and shows anger towards his bedside staff
- He makes vague comments about what he will do to 'this place' if his pain isn't better
  - As a result, nurses report they feel threatened by the patient and afraid to administer care

"Mr A continues to be combative with care. Will not allow assessment, and harming environment. Please advise."

What else would be helpful to know?

Mr A: Admitted with spinal hardware infection

In talking with Mr A, you discover:

- Frustrated with new major back problem and chronic pain
- Feels ‘cooped up’ in the hospital, particularly in semi-private room, due to noise and lack of privacy
- Feels anxious a couple times a week even when not in hospital
- Pain improved by walking around the hospital, sitting outside, and visiting the coffee or gift shops
- Smokes 1 ppd when not in hospital. Cuts down to 3-5 cigarettes a day when admitted.
- Feels 'judged' by hospital staff when asking for pain medications

How should we approach next steps in Mr A's care?

A Reminder of the Steps

1. Capacity? ☑
2. ‘Meet’ the patient
3. Gather your team
4. Specify risks to patient & others
5. What else can mitigate risk?
6. Patient-informed choice

Compassionate Boundaries

The Case of Mr A

Step 1: Capacity Assessment

- Mr A has capacity to understand the benefits of being in the hospital, and the hypothetical dangers of not receiving the prescribed care.

Step 2: 'Meet' the patient

Aside from being 'non-adherent' to requests to not yell or threaten staff, how can we frame his behavior?

- Likely anxiety component contributing to his worsened pain
- Nicotine withdrawal contributing to anxiety & restlessness

The Case of Ms. T

What can we do to 'Meet' Mr A where he is?

- Discuss options for management of anxiety, & medical care-related traumatic stress.
- Use Trauma-Informed Care approach. Offer Psychiatry expertise
- Offer nicotine replacement treatment
- Identify triggers to behaviors

Step 2: 'Meet' the Patient

Trauma-Informed reflection to inform next steps

- "It is helpful for us to be aware of the things that can help you feel better when you're having a hard time. Have any of the following ever worked for you?"
    - *We may not be able to offer all these alternatives but I'd like us to work together to figure out how we can best help you while you're here*
- Is there a person who is helpful to you when you're upset?
    - *Can we contact them your behalf when you're upset?*
- What are some of the things that make it more difficult for you when you're already upset?
    - *Are there particular "triggers" that you know will cause you to get more upset?*

Step 2: 'Meet' the Patient

Trauma-Informed reflection to inform next steps

– *"It is helpful for us to be aware of the things that can help you feel better when you're having a hard time. Have any of the following ever worked for you?*"

voluntary time out in your room		listening to music	
voluntary time out in quiet room		reading a newspaper/book	
sitting by the nurses station		watching TV	
talking with another consumer		pacing the halls	
talking with staff		calling a friend	
having your hand held		calling your therapist	
having a hug		pounding some clay	
punching a pillow		exercise	
writing in a diary/journal		using ice on your body	
deep breathing exercises		putting hands under cold water	
going for a walk with staff		lying down with cold facecloth	
taking a hot shower		other? (please list)	
wrapping up in a blanket			

Step 2: ‘Meet’ the Patient

Expectation Setting:

- Trauma-Informed team response to frustrations
  - How can patients expect team to respond?
- Patient Safety Care Plan
  - Patient-facing, **explicitly states behavior expectations**
  - Emphasizes patients & care team working together

Patient Safety Care Plan: An Example

Welcome to General Medicine
at UPMC Presbyterian

Thank you for trusting us with your care. We strive to keep a safe environment for our patients, staff, and visiting support persons. You are the most important member of your care team. **We want to work together with you to regain your health and maintain your safety.**

MEDICINES: We encourage you to tell us about your needs, especially if you have any feelings of anxiety, stress, pain, withdrawal, or concerns about medicine management. Honesty about your needs allows us to better help you.

For your safety, it's important that you **do not:**

- Take any medicines other than what your nurse gives to you
- Use any illegal substances, alcohol, tobacco products or vape
- Remove pain patches applied by your nurse
- Touch any buttons on your IV pump

Patient Safety Care Plan: An Example

COMMUNICATION: We are committed to providing high quality care centered around your needs. **We are always here to help you.** If you have concerns about, or disagree with, your treatment plan, please talk to us. We don't know unless you tell us.

- Please communicate respectfully. We will always listen, but know that using obscenities, yelling, threatening us, or throwing objects makes it harder for us to clearly hear your concerns.

UNIT GUIDELINES:

- For your safety, please do not leave the unit unless pre-approved by your care team.
- UPMC is a non-smoking facility. Patients are not permitted to smoke.
- If you would like to leave the unit, please discuss with your team so that a plan of care can be developed. This allows us to ensure you can receive your prescribed treatments and remain safe while in the hospital.
- For your safety and the privacy of others, please do not enter other patient rooms or go to other hospital units.

SUPPORT PERSON: This person provides you with important emotional support during a difficult time. We encourage you to identify a support person for your stay.

- Gently remind them that they are here to positively impact your care. They should not interfere with your treatment.
- They should leave by 9 p.m. so that you and other patients may receive much-needed rest.

Step 3: Gather your Team

Involve all who can help:

- Attending
- Nurses: Bedside & Leaders
- Behavioral Health Specialists – Nurses & Physicians
- Consultants
- Risk Management / Legal, if needed

Set the tone:

- Team Leadership - Motivating & coaching team to:
- Use De-escalation skills
  - Apply Trauma-informed approach to preventing escalation
  - Consider role of bias in assessing our reaction to behavior

Step 3: Gather your Team

Ask if bias is playing a role:

- Sun, et al. in Health Affairs, 2022.
  - Negative Patient Descriptors: Documenting Racial Bias in the EHR
- Association of patient factors with words in EHR, like:
  - 'Refused'
  - 'Non-compliant'
  - 'Agitated'
- Black Patients: adjusted OR = 2.54 (CI: 1.99, 3.24) more negative descriptors compared with White patients
- Medicaid: adjusted OR = 2.66 (CI: 2.08, 3.40)
- Medicare: adjusted OR = 2.08 (CI: 1.57, 2.75)

Step 4 & 5: How can the team identify and balance specific risks?

Multidisciplinary discussions of risks & potential care plan changes to minimize harm

- Nurses: Bedside & Nurse Leader
- Behavioral Health Nurse Specialist
- Consultant teams
- Risk Management or Legal team if needed
  - What risks are each concerned about?
  - What changes in care plan are feasible?
  - What are options for outpatient management?
    - What is difference in treatment success of these outpatient options?
  - What else can be done for overall harm-reduction?

Step 4: Specify risks -- to patient & others

What is worrisome about Mr A raising his voice, and calling names or making vague threats to staff?

Patient-Centered:

- Fractured communication about symptoms and treatment plan increase chances of things being missed
- Less attention to what he needs because staff feel threatened

Team-Centered:

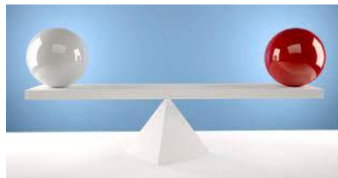
- Emotional health and safety of staff
- Staff retention and continuity of care team
- Distraction from the care of other patients

Step 5: As a Team, what else can mitigate risk?

Are there potential alterations to Mr A's care plan that could potentially reduce the risk of these things occurring?

- If behavior is worse at night ...
  - Perhaps adjust timing of care and medications to avoid nighttime interactions
- If dressing changes are a trigger ...
  - Perhaps give patient two options of when dressing changes are feasible
- If staff feel unsafe with every visit to his room ...
  - Ensure and instill confidence in de-escalation and avoidance strategies
  - Repeat your support of staff to judge and act to prioritize their safety, when needed

Finding a balance of risks can be challenging. Always involve Nurse Leaders, relevant Consultant teams in these discussions. If needed, Legal & Risk Management team should be included.



Step 6: Patient-informed choice conversation

1. Common Goal: **The benefits** to Mr A of being in hospital
   - *'**We** are caring for you in the hospital … because **we want you to get better**.'*

2. Risks of behavior & changes to care plan ***if*** his behavior continues, to reduce chances of harm
   - '**If-Then**' statements

3. You **value his autonomy & his right to choose** the care best for him
   - *'What concerns do you have?'*

Step 6: Patient-informed choice conversation

4. Respond with **empathy**
   – You are committed to caring for him & seek a therapeutic relationship

5. Teach-Back: You care that he's making **an informed choice**
   - *'To help me, can you explain back to me what we've discussed here?'*

6. (Document, so others can be consistent with you)

Step 6: Patient-informed choice conversation

Step	Objective	Description	Skill
1	**Common Goal**	Express a common goal with the patient	"We" statements
2	**Care plan and consequences**	Explain care plan, reasons, consequences	"If-then" statements
3	**Patient concerns**	Ask patient about their concerns	Open-ended questions
4	**Empathy**	Express empathy	NURSE statements
5	**Check for understanding**	Ensure patient understands plan	Teach-back

Practice this language with your team and/or nurse leader

Step 6b: Document the four key components of Patient-Informed Choice conversation:

1. Describe the High-Risk Behavior
2. Document Risks to Patient & Others of High-Risk Behavior
3. Describe *Option 1*: Patient stops (or reduces) behavior
4. Describe *Option 2*: Patient continues behavior, and care plan changes (e.g. medication stopped, UDS, or discharge)

The note can be entered by nurse leaders and any physician or APP

Non-Adherent Behavior Communication Note: An Example

PowerNote Name: Non-Adherence Communication Note
PowerNote Type: IP-Event

- Date/Time of Discussion with Patient: *[Date/Time]*
- Staff Attendees: (select all that apply) *Bedside Nurse, Resident, APP, Attending, Charge RN, Unit Director, Care attendant, PCT*
- Other Attendees: (select all that apply) *Patient Significant Other, Child, Parent, Sibling, Friend, Other*
- Describe Observed Non-Adherent Behavior: *[Free Text]*
- Specific Risks (to patient or staff) of Behavior, if continued: *[Free Text]*
- Requested Change in Patient Behavior: *[Free Text]*
- Relevant Consultant Recommendations: *[Free Text]*
- Anticipated Actions by Care Team if Non-Adherent Behavior Recurs: *[Free Text]*
- Discussed with and approved by Attending: *[Attending Selection Field] (Mandatory)*

I attest that I discussed with the patient the observed behavior, risks of this behavior, and consequences of continuing this behavior, as described above. *(Mandatory Selection)*

TIME TO REFLECT… THIS IS *HARD*

Let's Summarize

What makes managing HRNA behavior less difficult?

- HYPER-COMMUNICATE & DOCUMENT with your team
  - Bedside Nurse: Report & Document Patient Behavior
  - Nurse Leaders: Communicate expected behaviors
  - Attending: Balance Benefit/Risk of ongoing hospitalization, communicate expected behaviors
  - Consultants: Ask about Alternative Treatment Options
  - Crosscovering Providers: Report & Document Patient Behavior, Re-enforce expected behaviors

What makes managing HRNA behavior less difficult?

- Ask for help with liability, ethics, or communication
  - Risk Management team: Available 7-days a week
  - Ethics Consult team
  - Patient Relations

What's the use? This isn't going to stop…

- It really does help to:
  - Document observed behaviors
  - Discuss observed behaviors with care team
  - Develop shared understanding of risks among care team to reduce our biases
  - Discuss risks with patients & empowering patient-informed choices
  - Discuss ways to mitigate risk to patients and staff

We won't be able to eliminate high-risk behavior…

- Success will be a decrease in:
  - Aggressive behavior traumatizing staff
  - High-risk behavior while hospitalized (e.g. use of illicit substances, or smoking in bathroom)
  - Moral distress in clinical team managing these scenarios
  - Biased treatment of patients (based on race or medical history)

Pearls when times are tough

Behavior tends to be episodic, often flaring every 2-4 days.

- **The Approach**: Re-set expectations – any day without behavior is a win

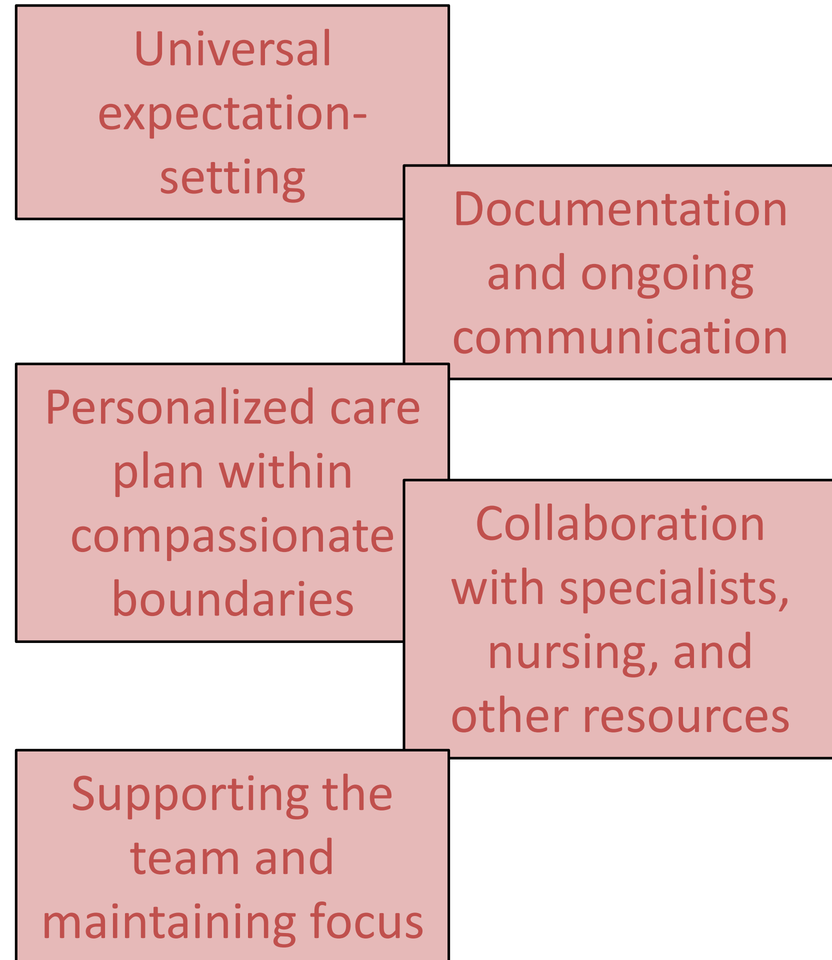
Prophylactic conversations about behavior – including praise and thanks – can be preventative

- **The Approach**: Don't avoid the topic on daily rounds, or skip checking in with your team just because it hasn't been an issue in last 24hrs.

The lack of an end-point (unclear disposition goals) increases mental burden of daily care

- **The Approach**: When times are tough re-focus the team on the light at end of tunnel

Managing Inpatient High-Risk Behavior: *The Keys*



This is hard. Maintaining focus on the patient, communication among the teams, and daily re-balancing of risks will be central to success.

Questions?

Management of risky inpatient behavior:
How to manage patient choices when stakes are high

October 20th, 2023

Dr Allison DeKosky &
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Acknowledgements

UPMC-based Project Team Members

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For additional resources, we suggest:

University of Colorado-Boulder-

- **Deesclation training:**
  - Simpson SA, Rylander M, Medlin H, Albert L. May 2017.
  - Verbal de-escalation of the agitated patient. Chapter 1: Identification and assessment of agitation - YouTube
  - Simpson SA, Rylander M, Medlin H. May 2017.
  - Verbal de-escalation of the agitated patient. Chapter 2: Basic elements of verbal de-escalation - YouTube