De-Escalation and Safety Intervention in Mental Health Crisis

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De-Escalation and Safety Intervention in Mental Health Crisis

Rebecca Mitz, BSN, RN

University of San Francisco

School of Nursing and Health Professions
Clinical Leadership Theme

This project focuses on the CNL curriculum element of Care Environment. The CNL role function is System Analyst/Risk Anticipator. Utilizing the resources available to me, I will implement staff training seminars to teach de-escalation strategies in order to improve how staff respond and intervene in an escalating mental health crisis. The aim of this project is to effectively de-escalate a situation in which a patient is experiencing a mental health crisis before it becomes uncontrollable to improve unit safety as well as patient outcomes.

Statement of the Problem

Approximately 1 in 5 adults in the U.S. experiences mental illness in a given year. Approximately 1 in 25 adults in the U.S. experiences a serious mental illness in a given year that substantially interferes with one or more major life activities (National Alliance on Mental Health, 2017). Psychiatric emergency services play a critical role in helping these individuals who suffer from an acute mental health event recover and return to being a functioning member of society. Without proper intervention in a crisis situation, situations have the potential escalate and result in negative outcomes, such as violence and aggression, which inhibit a patient from receiving the professional help they need.

My project is to be implemented in a psychiatric urgent care clinic, where patients who are experiencing an exacerbation of a mental illness, but who do not have any acute medical conditions, can voluntarily present and be treated for up to 20 hours. The microsystem consists of a staff mix of nurse practitioners (NPs), registered nurses (RNs), licensed vocational nurses (LVNs), and licensed psychiatric technicians (LPTs), all of whom have been trained in their profession but not properly or professionally trained on how to communicate with patients in crisis. Mental health care professionals are already at an increased risk for workplace violence;
the U.S. Department of Justice reported mental health occupations as the second highest average annual rate of workplace violence, with law enforcement having the only higher rate (Ridenour et al., 2015). Due to the fact that our patients are experiencing some degree of psychosis, there is greater potential for situations to escalate quickly and result in negative outcomes for both patients and staff, such as violence, involuntary detention of a patient, hospitalization of a patient, or patient expulsion from our services.

**Project Overview**

My project is to be implemented in a psychiatric urgent care clinic located in the heart of urban San Francisco. Our clientele consists of individuals experiencing an exacerbation of a mental illness or a substance use-related crisis. Furthermore, many of our patients are homeless and experience an extremely diminished quality of life due to uncontrolled mental illness and substance abuse. Our clinic is in partnership with San Francisco Law Enforcement, with psychiatric services at San Francisco General Hospital and at University of California, San Francisco, and with various case management and community mental health services across San Francisco. Patients are referred to us through these services and can be admitted voluntarily to our clinic for up to a 20-hour period in which they receive psychosocial rehabilitation.

This microsystem consists of a staff mix of NPs, RNs, LVNs, and LPTs, all of whom have been trained in their profession but not properly or professionally trained on how to communicate with patients in crisis. As our patients are experiencing some level of psychosis or psychiatric crisis upon admission, there is great potential for crises to escalate and turn negative without appropriate intervention. Therefore, my project aims to address this potential by better preparing staff to intervene in escalating situations, in turn improving safety and decreasing the number of adverse patient outcomes related to these events. More specifically, the goal of this
project is to decrease the number of incidents in which patients are escorted out of the clinic via staff or SFPD due to violent or aggressive behavior, are put on a 5150 hold, or who are absent without official leave (AWOL) or leave against medical advice (AMA) by 70% within 12 months of initiating an evidence-based staff training program on therapeutic communication and de-escalation techniques and implementing a de-escalation and safety intervention protocol. Furthermore, after staff training and implementation of the protocol, staff will report feeling more confident and prepared to de-escalate escalating events than they had before the training and without a standardized protocol. Realization of these goals will result in improved unit safety and improved patient outcomes.

**Rationale**

Through conducting a microsystem assessment and observing the workflow and interactions between staff and patients, I recognized inconsistent patterns of communication between staff and patients. The purpose of this microsystem is to promote rehabilitation and encourage the highest level of self-sufficiency for individuals who are considered severely disabled due to mental illness. While the microsystem functions well in many ways, there are areas that can be improved to maximize the care provided (See Appendix A for full SWOT analysis). The lack of consistent therapeutic communication skills inhibits the formation of a therapeutic alliance between patient and staff, which is essential in providing effective care to psychotic patients. I reviewed the process taken when a new staff member is hired, and no mental health or crisis intervention training is required or implemented. Instead, new-hires learn from shadowing more experienced staff and through their own personal experiences in these situations. The lack of standardized staff training in caring for patients experiencing mental health crisis is a major contributor of the mismanagement of situations when they do begin to
escalate, which then results in adverse patient outcomes and compromised safety for both staff and patients. Refer to Appendix B for the full cause and effect diagram of factors that contribute to this dilemma.

I further assessed this problem by analyzing microsystem data regarding patient discharges from January 1, 2016 to December 31, 2016 (Appendix C). I reviewed every patient’s chart who was admitted between these dates and recorded how and where they were discharged in one of the following categories: police escort due to violent or aggressive behavior, staff escort due to violent or aggressive behavior, police escort to a psychiatric emergency department on an involuntary hold (5150), emergency medical services (EMS) due to a medical issue, discharged to a detoxification program (social or medical), discharged to a residential treatment program or acute diversion unit, discharged back into the community, absent without official leave (AWOL) or left against medical advice (AMA), discharged to their case manager, discharged to return to their residence, or discharged to Homeward Bound services. The aggregate data revealed that in the year 2016, out of 2,107 admitted patients, 55 patients (2.6%) were removed due to violence either by staff or police, 39 patients (1.9%) were transferred to a psychiatric in-patient unit on 5150 hold, and 102 patients (4.9%) were AWOL or left AMA. While these statistics may seem relatively low, they add up to a total of 196 adverse/premature patient discharges in 2016 (9.3%), or an average of 16 to 17 incidents a month. As the primary purpose of our clinic is to promote rehabilitation from a crisis state for our patients, these statistics display the need for improvement.

While this quantitative data source alone does not substantiate the specific need for advanced staff training to decrease adverse/premature patient discharges, the exit notes at the time of discharge provide qualitative data that proves the need for improved therapeutic
communication and de-escalation techniques. In every adverse discharge recorded above, the events summarized in the exit note by the staff member/s involved in the outcome revealed poor communication and inconsistent intervention. This data indicates that adverse/premature patient discharges can be reduced through formal, evidence-based staff education and training on therapeutic communication and de-escalation techniques and implementation of a standardized protocol.

**Methodology**

To implement my change, I will apply Lewin’s change theory of unfreezing, moving, and refreezing. The first stage, “unfreezing,” is already in motion. I have been creating a sense of urgency among staff about the need for the change. To do this, I have been collecting and sharing my data with the stakeholders and the rest of the staff. I have been interviewing staff on how they feel in regards to escalating situations and their ability to adequately control the situation. I have provided evidence-based practices and statistics to prove the potential of this change. I have provoked thought and facilitated personal reflection from staff, which has in turn motivated them to support my project.

The next step of facilitating the change is the actual implementation and “moving” phase of the change (Appendix D). To implement my change and improve de-escalation techniques used by staff in an escalating situation, I plan to attend a Mental Health First Aid course in adult mental health. This is an 8-hour, evidence-based and peer-reviewed course that is managed, operated, and disseminated by the National Council for Behavioral Health. This program teaches how to identify, understand, and respond to signs and symptoms of an escalating mental health crisis (National Council for Behavioral Health, 2013). Once I have completed this course, I will use the information I learn in conjunction with other evidence-based research to initiate a
de-escalation and safety intervention protocol for staff to utilize when an escalating event occurs on the unit. This plan will designate specific roles and actions for every staff member, so that when a situation begins to escalate every team member will have a dedicated role to play in de-escalating the situation before it becomes uncontrollable. This action plan will be similar to a “code” response that is used in the hospital setting. It will be considered a code for crisis intervention when a patient is behaving potentially dangerous towards himself or others. I will initially provide this information to staff through an educational staff in-service.

Once this project has been implemented, this change will become “the norm,” hence, the “refreezing” phase of Lewin’s theory. This new de-escalation and safety intervention will be protocol for every escalating event and will be incorporated into all new staff orientation and training. Furthermore, simulations to practice and maintain understanding of roles will be conducted once every three months after initiation. This will ensure that the change sticks and becomes accepted as the intervention to take in escalating patient crises.

To check the effectiveness of my project, I will monitor data regarding patient discharges. Within 12 months after the initiation of the education and training in-service and implementation of the de-escalation and safety intervention protocol, a reduction in the number of incidents in which patients are escorted out of the clinic via staff or SFPD, are placed on a 5150 hold, or who are AWOL/leave against medical advice by 70% will indicate that my project has been successful and that I have reached my desired goal. I will conduct a pre-test and post-test before and after staff education and training to evaluate staff perception of the usefulness of the education and training. I predict that within 12 months, adverse/premature discharges as indicated by the patient discharge data will decrease by at least 70% and I will realize my goal. I
also predict staff will report feeling more confident in their intervention and de-escalation skills after the training.

**Cost-Analysis**

The implementation of my project is cost-effective. Administration has approved the time and budget for teaching staff and this project will be funded by the staff education and training fund. The cost of training one person (me) in an adult course in Mental Health First Aid is $179, plus $25 for course materials. Therefore, the total cost of the Mental Health First Aid training is $204. As I will utilize the information I learn to educate staff and formulate a de-escalation and safety intervention protocol, all 20 staff members will need to participate in 1 hour of paid in-service training. Of these 20 staff members, 4 are NPs with an average salary of $60/hour, 4 are RNs with an average salary of $40/hour, 8 are LVNs/LPTs with an average salary of $25/hour, and 4 are counselors with an average salary of $17/hour. Accordingly, the total cost of in-service training for this staff mix is $668. 4 hours of paid simulation training will be conducted 4 times a year after the implementation of this change. Therefore, the total cost of implementing this change in the first year is projected to be $11,560, and maintaining the change will cost an additional $10,688 per year for staff participation in simulation training (Appendix E), which will be conducted by the program/nurse director.

However, the potential cost-savings of this project clearly outweigh the costs. From January 1, 2016-December 31, 2016, a total of 196 adverse/premature patient discharges were recorded due to an uncontrolled escalated incident. Patients can stay at the clinic for up to 20 billable hours at $85/hr, and from a revenue standpoint we want patients to stay for the full 20 hours. If the average length of stay for all patients who leave the clinic early due to escalated events is 10 hours, we are losing revenue. Therefore, realizing my goal and decreasing these
events by 70% can increase our revenue by up to $116,620 in one year and result in a net benefit of $105,060 for the microsystem in the just the first year of implementation.

There are also cost-savings that will benefit the city of San Francisco as well. Of the 196 cases of patients being removed from the clinic, 39 of these cases have resulted in a 5150 hold requiring police and Emergency Medical Services (EMS). Each time EMS is used, $1,642 is billed to the city just for transportation. Each mile traveled costs an additional $31 (City and County of San Francisco, 2012). The distance from our clinic to San Francisco General Hospital (SFGH) Psychiatric Emergency Services (PES) is 1.6 miles; therefore, the total cost billed to the city per transfer is $1,691.60 and these 39 cases recorded in 2016 cost the city a total of $65,972.40. By implementing this project and realizing my goal of decreasing these incidents by 70% in the next year, this would save the city $46,180.68.

**Literature Review**

The literature surrounding mental health nursing and mental health crisis support the concept that de-escalation training can lead to improved microsystem safety and improved patient outcomes. From 2005 to 2009, the U.S. Department of Justice reported mental health occupations as the second highest average annual rate of workplace violence, with law enforcement having the only higher rate (Ridenour et al., 2015). Furthermore, a study by Hesketh et al. found that during a given work week, 20% of psychiatric nurses were physically assaulted, 43% were threatened with physical assault, and 55% were verbally assaulted at least once, while another study of 8 acute psychiatric units throughout the United States found that the overall rate of verbal aggression incidents per nurse per week was 60% and the overall rate of physical aggression incidents per nurse per week was 19% (as cited in Ridenour et al., 2015). This research shows that risk for violence in mental health/psychiatric nursing is much higher.
than in other areas of nursing and supports the need to be prepared to handle violent or aggressive situations in order to maintaining a safe environment for both patients and staff.

Communication is a fundamental component of all therapeutic interventions, especially when aiming to control an escalating situation with a patient in mental health crisis. According to Robertson, Daffern, Thomas, and Marten (2011), de-escalation relies on specific communication skills and the ability to assess the potential impact of a situation. Llor-Esteban, Sanchez-Munoz, Ruiz-Hernandez, and Jimenez-Barbero (2017) contend that staff who are more experienced have been correlated with lower rates of violence and that, therefore, implementing training plans that include necessary communication skills to manage conflictive situations can lead to a decrease in number of aggressions. Sandhu, Arcidiacono, Aguglia, and Priebe (2015) explain that openness and honesty, willingness to listen, empathy, non-judgmental reflection, positive regard, acceptance, and emotional involvement help to create reciprocal relationships and are behaviors that are recognized as what makes for good communication and therapeutic relationships in mental health care.

Swain and Gale (2014) conclude that staff can often contribute towards triggering aggressive acts by patients and, therefore, interventions that increase staff communication skills can reduce workplace aggression. Jensen and Clough (2016) determine that the formation of a therapeutic alliance with a patient experiencing psychological distress relies on skilled communication and interpersonal skills and is critical in de-escalating and managing the situation. The authors explain that the relationship formed with the patient is “the primary intervention tool that is used for successful outcomes” (Jensen & Clough, 2016, p. 191). Additionally, Price and Baker (2012) explain how violence again staff typically results from
nurse-patient interactions, suggesting that improving ways in which staff communicate with patients can help reduce violent incidents.

De-escalation in mental health nursing must involve recovery-oriented care. Recovery oriented care is care that revolves around the belief that individuals experiencing mental health challenges can and will get better (National Council for Behavioral Health, 2013). When staff are challenged in managing mentally distressed patients who are aggressive and agitated, this can encourage hostile and ineffective interventions. Ramirez and Murphy (2012) contend that in order to provide safe and effective care to mentally ill patients in distress, de-escalation must include a decision-framework to take appropriate action. Furthermore, according to a study conducted by Gilburt, Slade, Bird, Oduola, and Craig (2013), mental health providers who participated in a recover approach training program had improved patient care outcomes compared to the control group of mental health providers who did not participate in the program. Newman, O’Reilly, Lee, and Kennedy (2015) conclude that there is a need for the provider-patient relationship to better facilitate the patient’s total engagement in their care to improve patient outcomes.

Utilizing the PICO search statement of mental or behavioral health/psychological distress/acute psychosis (population), de-escalation techniques/therapeutic communication/recovery therapy (intervention), no specialized training (comparison), and decrease in violence/adverse outcomes or improved patient outcomes/safety (outcome), I was able to yield the above research that supports the need for my project. As noted, the literature discusses the increased risk for violence in mental health nursing as well as the significance of skilled therapeutic communication and recovery focused de-escalation methods in managing care for mental health patients in crisis.
Timeline

The project will begin on April 10, 2017 when I partake in the 2 part 8-hour Mental Health First Aid course. After completion of this course, I will use the information I learn in conjunction with other evidence-based research to formulate an educational teaching and de-escalation and safety intervention protocol to be used on the unit. On April 19, 2017 I will conduct a staff education in-service to teach the new de-escalation and safety intervention protocol and discuss de-escalation techniques. One week later, on April 26, 2017, I will administer a staff survey to evaluate the perceived effectiveness of the educational session and usefulness of the de-escalation and safety intervention protocol. This will end the implementation of my change. However, to maintain the project, simulations will be conducted at 3-month intervals in July, October, January, and April (Appendix F). After one year of implementation, in April 2018, patient discharge data will be collected to evaluate effectiveness. Additionally, the staff survey will be completed once again to re-evaluate perceptions after one year of implementing the protocol.

Expected Results

I expect to realize my goal of decreasing the number of incidents in which patients are escorted out of the clinic via staff or SFPD due to violent behavior, are put on a 5150 hold, or who are absent without official leave (AWOL) or leave against medical advice (AMA) by 70% within 12 months of initiating the action plan protocol for de-escalating escalating events. Furthermore, after staff education and initiation of the de-escalation and safety intervention protocol, I expect staff will report feeling more confident and prepared to de-escalate escalating events than they had before the training and without a standardized protocol. I expect that staff will express feeling more prepared and confident in their skills and abilities to therapeutically
communicate and manage patients who are experiencing an escalating crisis and will appreciate the structure and standardization of having a protocol to follow and refer to in time of crisis. While I hope to realize 70% improvement, I believe that results of this project will actually yield a higher percentage of improvement. Although I expect these results eventually, I do expect some resistance to participating in the in-service and simulation activities from a few staff members initially.

While I expect positive results from my project, I do think that staff would benefit from participating in a Mental Health First Aid training course themselves. If I had a larger budget I would have required all staff members to attend training in addition to learning my de-escalation and safety intervention protocol. I believe that the administrators and directors of the clinic will recognize the benefits of Mental Health First Aid training through this project and will eventually set aside funds to train all staff through this program to reinforce the methods I will teach through the protocol.

**Nursing Relevance**

Improving de-escalation techniques and formulating a standardized protocol for controlling escalating situations has many implications for mental health nursing. If the results are as positive as I am expecting them to be, this will reinforce the growing belief that professional and specific mental health training can be beneficial for helping individuals experiencing mental health crisis and in maintaining safety on a mental health unit. Therefore, this project can significantly support the need for staff education and training in mental health nursing and can influence the requirement of using a standardized protocol for de-escalation in all mental health and psychiatric healthcare settings.

**Summary Report**
My CNL Internship Project aims to better prepare staff to intervene in escalating mental health crises, in turn improving safety and decreasing the number of adverse patient outcomes related to these events. More specifically, the goal of this project is to decrease the number of incidents in which patients are escorted out of the clinic via staff or SFPD due to violent or aggressive behavior, are put on a 5150 hold, or who are AWOL or AMA by 70% within 12 months of initiating an evidence-based staff training program on therapeutic communication and de-escalation techniques and implementing a de-escalation and safety intervention protocol. Furthermore, after staff training and implementation of the protocol, staff will report feeling more confident and prepared to de-escalate escalating events than they had before the training and without a standardized protocol. This project is being implemented in a psychiatric urgent care clinic in the heart of urban San Francisco, where we provide rest and rehabilitation for individuals experiencing an exacerbation of a mental illness. Therefore, our patient population consists of many acutely psychotic individuals, increasing the potential for violence and aggression and compromised unit safety.

Through conducting a microsystem assessment and observing the workflow and interactions between staff and patients, I collected both quantitative and qualitative data to support the need for this project. I reviewed the process taken when a new staff member is hired; no mental health or crisis intervention training is required or implemented. Instead, new-hires learn from shadowing more experienced staff and through their own personal experiences in these situations. The lack of standardized staff training in caring for patients experiencing mental health crisis is a major contributor of the mismanagement of situations when they do begin to escalate, which then results in adverse patient outcomes and compromised safety for both staff and patients. I further assessed this problem by analyzing microsystem data regarding
patient discharges from January 1, 2016 to December 31, 2016 (Appendix C). The aggregate
data revealed that in the year 2016, out of 2,107 admitted patients, 55 patients (2.6%) were
removed due to violence either by staff or police, 39 patients (1.9%) were transferred to a
psychiatric in-patient unit on 5150 hold, and 102 patients (4.9%) were AWOL or left AMA.
While these statistics may seem relatively low, they add up to a total of 196 adverse/premature
patient discharges in 2016 (9.3%), or an average of 16 to 17 incidents a month. As the primary
purpose of our clinic is to promote rehabilitation from a crisis state for our patients, these
statistics display the need for improvement.

While this quantitative data source alone does not substantiate the specific need for
advanced staff training to improve safety and decrease adverse/premature patient discharges, the
exit notes at the time of discharge provide qualitative data that proves the need for improved
therapeutic communication and de-escalation techniques. In every adverse discharge recorded
above, the events summarized in the exit note by the staff member/s involved in the outcome
revealed poor communication and inconsistent intervention. Therefore, this data implies that
with the implementation of standardized staff education and training and utilizing a standardized
protocol to intervene in escalating or threatening situations, unit safety can be improved and
adverse patient outcomes can be reduced.

To implement this project, I attended an 8-hour Mental Health First Aid training course, a
nationally recognized, evidence-based, and peer reviewed certification program that teaches how
to identify, understand, and respond to signs and symptoms of an escalating adult mental health
crisis. I used the information and skills I learned through this training, along with other
evidence-based research, to create the De-Escalation and Safety Intervention in Mental Health
Crisis protocol (Appendix G) and to guide my staff education and training in-service. I also
created a “De-Escalation Techniques” handout (Appendix H) to supplement my teaching and to be hung on the unit for reference afterward. From April 18, 2017-April 22, 2017, I conducted 5 one-hours education and training in-service sessions. All staff members signed up and attended one of these sessions. These sessions consisted of an overview of evidence-based de-escalation techniques, explanation of the De-Escalation and Safety Intervention Protocol and expectations of staff, and a discussion of de-escalation techniques and application of the protocol. Prior to each in-service session, staff completed a survey (Appendix I) to collect baseline data of staff perception of preparedness to handle escalating patient situations. Immediately following each session, staff completed another survey (Appendix J) to evaluate the effectiveness of the training and their perception of usefulness of the protocol. The following week after the training, staff completed the same survey (Appendix I) that was given before training to re-assess perception of preparedness in handling escalating patient situations after implementing the protocol.

Baseline data collected from the pre-test staff survey (Appendix I) showed that the average perception of all staff was neutral (3/5) toward feeling confident in their abilities individually and as a team to effectively communicate and safely manage an escalating or threatening patient. Data collected a week following the training from administering the same survey (Appendix I) showed significant improvement. The average perception of all staff was rated 4/5, indicating that on average staff agree that they feel confident and prepared to safely manage an escalating situation both individually and as team. This overall increase in staff perception of preparedness realizes my goal of improving staff perception through education and training. Furthermore, results collected from the De-Escalation and Safety Intervention Post-Teaching Survey (Appendix J) revealed 100% of staff feel strongly (5/5) that the de-escalation
techniques discussed and the implementation of the standardized protocol are effective methods to incorporate into practice.

I was not able to evaluate the effectiveness of this education and training and implementation of this protocol on patient discharge data, as I only was able to conduct the training and begin the implementation process. However, I am confident that in April 2018 my goals will be realized and the number of incidents in which patients are escorted out of the clinic via staff or SFPD due to violent or aggressive behavior, are put on a 5150 hold, or who are AWOL or AMA will decrease by 70%. The positive feedback and increase in staff perception of preparedness show success of my education and training and leave me confident that staff will effectively incorporate the De-Escalation and Safety Intervention protocol into their practice.

To sustain this change, the plan is for the program/nurse director to conduct 4-hour simulation training sessions for staff four times a year, in July, October, January, and April. These simulations will include scenarios of violent or threatening patient situations and allow staff to respond accordingly, following the De-Escalation and Safety Intervention protocol. Furthermore, the “De-Escalation Techniques” handout (Appendix H) as well as the De-Escalation and Safety Intervention protocol (Appendix G) will be hung on the unit and will be incorporated into all new staff orientation and training.

The primary purpose of our clinic is to promote rehabilitation from a mental health crisis for our patients. In order to provide the highest quality care to our patients, safety must be a priority. The U.S. Department of Justice has reported mental health occupations as the second highest average annual rate of workplace violence, only behind law enforcement (Ridenour et al., 2015). In assessing the microsystem, ample data supported the need for improved intervention to maintain safety as well as improve patient outcomes. Through conducting staff education and
training on de-escalation techniques and implementing a standardized protocol that designates a role for all staff to play in an escalating and potentially threatening patient event, staff can confidently and competently intervene in an escalating mental health crisis to maintain unit safety and decrease adverse patient outcomes.
References


Ramirez, M., & Murphy, J. (2012). Teaching recovery concepts to mental health technicians.
*Archives of Psychiatric Nursing, 26*(5), 432-433. Retrieved from http://ac.els-cdn.com/S088394171200043X/1-s2.0-S088394171200043X-main.pdf?_tid=91a04f48-f7ab-11e6-9e97-00000aab0f02&acdnat=1487622873_11cb238eed023101ec47b6ea6e0da767


Appendix A

**SWOT Analysis**

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services available to a large population of people</td>
<td>Wide array of mental health conditions</td>
</tr>
<tr>
<td>Abundant resources for patients to receive additional mental health, substance abuse, and medical services and treatment programs</td>
<td>Lack of appropriate staff training for effective intervention for all mental health conditions</td>
</tr>
<tr>
<td>Prime location for targeted population</td>
<td>One room for all patients</td>
</tr>
<tr>
<td>Strong alliance with SFPD</td>
<td>Short LOS (&lt;=20 hrs) makes it difficult to provided lasting support to patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand knowledge base and skill level of staff using evidence-based practices to improve patient outcomes</td>
<td>Individuals abusing our services for a safe place to rest, bathe, and eat by exaggerating a mental health crisis</td>
</tr>
<tr>
<td>Implement standardize crisis “code” intervention to have a clear role for every staff to play in de-escalating situations that are intensifying, thus improving workflow and outcomes</td>
<td>Violence and threat to unit safety due to volatility of clientele</td>
</tr>
</tbody>
</table>
Appendix B

Root Cause Analysis: Fishbone Diagram

Staff
- Staff mix of NPs, RNs, LVNs, and LPTs
- No formal or standardized mental health training
- No formal or standardized crisis/de-escalation training

Patients
- Must be experiencing a mental health crisis/psychosis to be admitted
- Many patients are intoxicated at time of admission
- Many patients are homeless and are substance abusers
- Unpredictable/volatile
- Patients can have a hx of violence/aggression

Environment
- Small, 12 bed (chair) facility
- One room for all patients
- Nurse station in the back of facility

Process
- Only one staff member monitoring milieu
- Completely voluntary—patients can refuse medications that can mitigate psychosis yet are allowed remain in clinic for rest
- LOS 20 hours maximum

Mismanaged escalated events resulting in adverse patient outcomes and compromised safety
### Table 1: Patient Discharge Data: January 1, 2016-December 31, 2016

<table>
<thead>
<tr>
<th></th>
<th>Police d/t violent/ aggressive bx</th>
<th>Staff escort d/t violent/ aggressive bx</th>
<th>Police d/t 5150</th>
<th>EMS d/t medical issues</th>
<th>Detox</th>
<th>Residential treatment program</th>
<th>Self-Community</th>
<th>AWOL/AMA</th>
<th>Case manager</th>
<th>Self-Home</th>
<th>Home-ward Bound</th>
<th>TOTAL:</th>
</tr>
</thead>
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<tr>
<td><strong>TOTAL:</strong></td>
<td>15</td>
<td>40</td>
<td>39</td>
<td>34</td>
<td>125</td>
<td>567</td>
<td>996</td>
<td>102</td>
<td>30</td>
<td>135</td>
<td>24</td>
<td>2107</td>
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<tr>
<td><strong>PERCENTAGE OF TOTAL:</strong></td>
<td>0.71%</td>
<td>1.90%</td>
<td>1.85%</td>
<td>1.61%</td>
<td>5.93%</td>
<td>26.91%</td>
<td>47.27%</td>
<td>4.85%</td>
<td>1.42%</td>
<td>6.41%</td>
<td>1.14%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Appendix D

Process Map

Leader takes Mental Health First Aid course

Leader formulates educational in-service and de-escalation action plan protocol

Administer pre-test to staff to collect baseline data regarding staff perception of preparedness to deal with crisis

Leader conducts in-service education and training on de-escalation action plan protocol

De-escalation action plan protocol implemented on unit

Administer post-test to staff to evaluate their perception of effectiveness of education and action plan protocol

Simulation activities conducted to reinforce and maintain understanding of action plan protocol

Discharge data collected and staff survey conducted to evaluate effectiveness and success of project
### Table 2: Budget Estimates

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health First Aid</strong></td>
<td>$204</td>
<td></td>
</tr>
<tr>
<td><strong>Training Course:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1 hour staff in-service:</strong></td>
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<tr>
<td>. 4 NP x $60/hr</td>
<td>$240</td>
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<tr>
<td>. 4 RN x $40/hr</td>
<td>$160</td>
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</tr>
<tr>
<td>. 8 LVN/LPT x $25/hr</td>
<td>$200</td>
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<tr>
<td>. 4 Counselors x $17/hr</td>
<td>$68</td>
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<tr>
<td><strong>4 hour simulation activities, 4 times a year:</strong></td>
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<tr>
<td>. 4 NP x $60/hr</td>
<td>$3,840</td>
<td>$3,840</td>
</tr>
<tr>
<td>. 4 RN x $40/hr</td>
<td>$2,560</td>
<td>$2,560</td>
</tr>
<tr>
<td>. 8 LVN/LPT x $25/hr</td>
<td>$3,200</td>
<td>$3,200</td>
</tr>
<tr>
<td>. 4 Counselors x $17/hr</td>
<td>$1,088</td>
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<tr>
<td><strong>Total Cost:</strong></td>
<td>$11,560</td>
<td>$10,688</td>
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Appendix F

Timeline

TIMELINE
Implementing and Sustaining De-Escalation Action Plan Protocol: Year 1 Projection

START
April 10, 2017
Leader participates in Mental Health First Aid Course

April 19, 2017
STAFF IN-SERVICE
Staff participate in education and training on de-escalation and communication techniques and learn action plan protocol

April 26, 2017
STAFF SURVEY
Administer staff survey to evaluate perceptions of effectiveness of teaching and new protocol

July 2017
SIMULATION #1
Staff participate in simulation to reinforce learning and application of de-escalation protocol

October 2017
SIMULATION #2
Staff participate in simulation to reinforce learning and application of de-escalation protocol

January 2018
SIMULATION #3
Staff participate in simulation to reinforce learning and application of de-escalation protocol

April 2018
END
Simulation #4, evaluation of patient discharge data and staff survey to evaluate effectiveness and success of education and protocol
Appendix G

Protocol: De-Escalation and Safety Intervention In Mental Health Crisis

DE-ESCALATION AND SAFETY INTERVENTION IN MENTAL HEALTH CRISIS

Escalating Client

Violent or Threatening?

No

Continue verbal de-escalation techniques

Yes

Ask client to leave clinic

Client leaves on own

Client refuses and continues to escalate

Exit room safely, become TEAM LEAD

Call 911 OR Call Sheriff: (415) 551-3911

Alert and quickly debrief staff, delegate tasks

Assign uninvolved staff member to work with client

Calmly approach client

Ask client to leave

Assign staff member to scan area and remove hazardous objects

Support staff member working with escalating client

Continue to verbally de-escalate

Escort to door

Sheriff arrives

Assign remaining staff members to divert other clients away

Escort to safety outside if needed

Client leaves

Observe processes and step in where help is needed most
Appendix H

Handout: De-Escalation Techniques

DE-ESCALATION TECHNIQUES

• Trust your instincts! If you feel threatened for any reason, leave the situation
• Maintain a calm & soft yet firm tone—change of tone can have immediate affect on the client
  - Convey calmness, control, and willingness to help
  - Use a matter of fact, neutral approach
  - Use an “I” approach rather than a “you” command
  - Avoid becoming defensive or responding in a disrespectful manner
• Set clear, consistent, and enforceable limits at the beginning of the relationship
  - Remind the client that limits are being set on behaviors, not feelings
  - E.g., It is OK to feel angry, but it is not OK to be verbally abusive
• Always have a clear path to the exit
  - Do not position client in front of door
  - Sit/stand closest to door
  - Never turn your back on client
• Give the client space, staying at least one arm’s length away
• Active listening
  - Assess your own feelings and be aware if your feelings are interfering with your communication skills
  - Acknowledge the client’s feelings—identify the anxiety or anger and try to determine what is behind the anxiety/anger
• Cool-off period
  - If a client’s behavior threatens to escalate, inform the client that you are leaving the situation
  - Give client a time frame that you will return to continue conversation

THE DON’TS:

Don’t threaten the client
Don’t argue about the facts of the situation
Don’t tell the client that he/she has no right to be angry
Don’t become defensive
Don’t make promises you can’t keep
Don’t challenge the client
Don’t criticize the client
Don’t laugh at the client

THE DOS:

Use simple, direct statements
Encourage verbalization of anger rather than acting out
Assume that the client has a real concern and is understandably upset; acknowledge the client’s right to his/her feelings
Be empathetic
Offer alternatives
Appendix I

**Pre-test/Post-test: Staff Survey**

1 = Strongly Disagree; 5 = Strongly Agree

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel confident in my ability to communicate effectively with an escalating client.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>I feel confident in our ability as a team to effectively manage an escalating client/situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>I feel confident in our ability as a team to maintain safety for both clients and staff in the event a client becomes escalated.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>I have a clear understanding of what to do when a client become escalated.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>I get very anxious when a client behaves in an angry or anxious manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix J

De-Escalation and Safety Intervention Post-Teaching Survey

1 = Strongly Disagree; 5 = Strongly Agree

1. I learned something new about de-escalation techniques to utilize when dealing with a client experiencing a mental health crisis.

2. The De-Escalation and Safety Intervention Protocol seems like a reasonable intervention to incorporate into my practice.

3. The De-Escalation and Safety Intervention Protocol seems easy to follow.

4. The De-Escalation and Safety Intervention Protocol is a useful intervention for managing escalating mental health crises.

5. I would implement the De-Escalation and Safety Intervention Protocol in my practice.