CLAIMS

CLINICAL & RISK MANAGEMENT PERSPECTIVES

JANUARY 2019

Approaches to Managing Disruptive Patients

Case One | Failure to Use De-escalation Strategies

Case Two | Terminating Treatment of Disruptive Patients

Special Feature | Triggers of Disruptive Behavior

Special Feature | Service Failures and Unanticipated Outcomes

Special Feature | Nonverbal Cues of Imminent Interpersonal Violence

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Approaches to Managing Disruptive Patients

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By reviewing medical professional liability claims and/or emerging topics in healthcare risk management, this enduring material series will support your ability to:

- Assess your practice for risk exposures.
- Apply risk management best practices that increase patient safety and reduce medical professional liability claims.

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EDITOR

Mary-Lynn Ryan, JD
Risk Management Specialist,
NORCAL Group

CONTENT ADVISORS

Sandra L. Beretta, MD
Chair, NORCAL Mutual,
FD Insurance, Medicus and
Preferred Physicians Medical RRG

Patricia A. Dailey, MD
Director, Preferred Physicians
Medical RRG

Rebecca J. Patchin, MD
Director, NORCAL Mutual,
FD Insurance and Medicus

William G. Hoffman, MD
Family Practice Content Advisor

Dustin Shaver
Vice President, Risk Management,
NORCAL Group

Paula Snyder, RN, CPHRM
Regional Manager, Risk Management,
NORCAL Group

Katey L. Bonderud, MHCA
Claims Specialist, NORCAL Group

Kellie N. Sorenson, JD
Sr. Counsel, NORCAL Group

PLANNER

Shirley Armenta
CME Program Lead, NORCAL Group

INTRODUCTION

"Anger is the way people respond to unmet needs or expectations. Most of the time the anger (rightly or wrongly) is directed toward the physician because he or she is the most convenient and visible target."[1]

Disruptive patient behavior, particularly violence, is a growing problem.[2] Disruptive behavior can be defined broadly as patient behavior that jeopardizes the health and safety of others or that impedes or disrupts the ability to provide healthcare.[3] It can include threatening, profane, sexual or offensive comments and gestures, violence or aggression. Disruptive patients who threaten or inflict actual physical harm to clinicians and staff (which has psychological effects[2]) also undermine their own health. For example, a disruptive patient is more likely to miss appointments, less likely to comply with treatment recommendations and, therefore, will generally have worse health outcomes.[4] Finally, there are liability risks associated with disruptive patient management. Patients who remain angry and dissatisfied following a healthcare encounter are more likely to pursue malpractice lawsuits.[4,5]

Different kinds of disruptive patients require different de-escalation and follow-up strategies. For example, de-escalation strategies may be too dangerous if the patient has a weapon. In those cases, the police/security should be called, and immediate termination of treatment is appropriate. On the other hand, a patient who is disruptive because of a perceived service failure might be successfully calmed to a degree that the basis for his or her anger can be discovered and remedied. In that case, the appropriate follow-up might be a behavior warning or a patient behavior agreement. Sometimes, disruptive patient behaviors destroy the therapeutic relationship. In that case, termination of treatment with proper notice may be appropriate.

The case studies in this month's publication are based on NORCAL Group closed claims and Risk Management Department calls from insureds. The case studies provide the basis for strategies that can be used to identify catalysts to patient agitation and violence, de-escalate disruptive behavior and appropriately follow up disruptive patient encounters. Ideally, by using these strategies, clinicians and staff can recognize risk factors for disruptive behavior and mitigate or prevent an incident so no one gets hurt and patients receive the healthcare they need and reasonably expect.

Failure to Use De-escalation Strategies

In the following case, the patient and her husband were removed from the emergency department (ED) for using profanity and issuing threats. From the hospital's point of view, the security guard and nurse appropriately followed the policy and protocol for disruptive patient management. From the patient's point of view, the ED was providing bad service and was not solving her medical issue. It is likely that this patient would not have become disruptive if her treatment had been more coordinated and if the staff had used de-escalation techniques. Consider what could have been done differently.

Although this case took place in an ED, the de-escalation strategies presented can be used in multiple healthcare settings.

CASE ONE

Allegation: Delayed diagnosis of epidural abscess resulted in paraplegia.

On a Monday, a woman presented to the ED via ambulance with lower back pain reported as 10 on a scale of 1-10. She was given Percocet, which eventually diminished her pain to 6/10, but within the hour she was back at 10/10 and began loudly moaning and writhing on the examination table. She was then given IV pain medications, which brought her pain down to a manageable level. She was discharged with a diagnosis of muscle strain, given a prescription for Percocet and muscle relaxants, and instructed to follow up with her primary care physician.

On Tuesday, the patient awoke with excruciating back pain. The Percocet and muscle relaxants did not give her any relief. She returned to the ED via ambulance. The ED physician ordered an MRI, but when it was attempted, she was unable to lie still because of the pain. She begged for intravenous pain medications to help her get through the MRI. She explained to the radiology tech that the intravenous drugs had worked the previous day. The radiology tech reported the patient's inability to tolerate the MRI back to the ED physician. He also passed on the patient's request for IV pain medications. The ED physician ordered oral Percocet. Her plan was to try Percocet first, then try stronger pain medications if the Percocet did not achieve the pain relief necessary to allow the MRI to go forward. She did not review the patient's record from the previous day. The patient was then brought back to the waiting room, where a nurse brought her Percocet, explaining it would relieve her pain and allow her to lie flat for an MRI. Very loudly, with a sprinkling of expletives, the patient informed the nurse she had been taking Percocet for the past 24 hours and it wasn't working. She demanded to be given the same intravenous pain medications she had been given the previous day. The nurse informed the patient that injections were not given in the waiting room. When the patient's husband asked when the patient could get an MRI, the nurse replied, "It will be a while." Hearing this, the patient loudly made vague threats about hurting people if she didn't get intravenous medications immediately. When the nurse gave her a warning about her language, telling her she would be removed from the premises if she did not calm down, the patient demanded to see a physician, refused to leave without getting an MRI, threatened to hire a lawyer and continued to swear and moan in pain. The security guard, at this point, determined the patient met the criteria for being removed from the premises, and wheeled her out to the parking lot.

One week later, the patient got an MRI, which showed marked spinal cord compression due to an epidural abscess. Emergency surgery was performed, but the patient sustained permanent neurological deficits. She sued every person on her healthcare team.

DISCUSSION

Like many patient injuries, this one was the result of a combination of systems and individual errors, including the patient's. Part of the problem was the patient's back pain. Back pain is the most common musculoskeletal complaint in the ED, and 90% of these complaints have a benign etiology.[6] It can be difficult for emergency physicians and staff to identify the 10% of back pain patients with a serious condition. Diagnosis becomes even more difficult if the patient cannot tolerate the best test for diagnosing critical back conditions. It didn't help the patient's situation that she and her husband were unpleasant, loud and demanding. Viewed in retrospect, the cause of the patient's mounting frustration, agitation and anger is understandable: She was in pain and she believed she knew the appropriate treatment, but she continued to be offered pain medication that was not working. While the threats to harm others and episodes of profanity are not excused, the entire episode might have been avoided if the ED nurse and/or security guard had used de-escalation techniques and advocated on behalf of the patient, instead of dismissing her request for intravenous pain medication and removing her from the waiting room. The ED physician also should have reviewed the patient's recent history and considered the radiology tech's information regarding proposed alternative pain relief in order to achieve the MRI more expeditiously. Delivering adequate pain relief was the key to avoiding a devastating injury and lawsuit — experts surmised that the epidural abscess would have been visible had the MRI been successful, and that the permanent nerve damage would have been avoided had she undergone surgery on Tuesday.

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RISK MANAGEMENT **RECOMMENDATIONS** — DE-ESCALATION

It is important to have disruptive patient policies and procedures in place, but these tools must have some flexibility to allow clinicians and staff to individualize the response depending on the potentiality of danger. Individualizing a response requires appropriate training; therefore, it is important for administrators to provide the necessary tools to clinicians and staff to facilitate safety while satisfying patient healthcare needs. Consider the following de-escalation strategies when dealing with an agitated patient:[2,7,8]

- Maintain two arms' length of space between you and the patient.
- Do not provoke the patient.
  - Avoid engaging in triggering behavior. (See, "Triggers of Disruptive Behavior" content below.)
  - Maintain your composure.
    - Know your own triggers that may escalate the tension between you and the patient.
      - When you are triggered, tell the patient you are going to leave and return in five minutes, and take a break.
        - Have a plan before you resume the encounter.
  - Suspend judgment of the patient's behavior.
    - Avoid questions that begin with "why," which can be perceived as judgmental.
    - Put yourself in the patient's shoes and consider how your tone/words are being received.
  - Use body language that is congruent with your words to avoid sounding insincere.
  - Do not interrupt unless it is to clarify.
  - Maintain an open posture.
  - Stand at an angle to the patient, which can reduce feelings of confrontation.
  - Do not attempt to control behavior that does not impact safety.
  - If you start the de-escalation, stay with the patient through the process. Interaction with multiple individuals can be confusing and increase the patient's agitation level.
  - Use short, concise sentences and simple vocabulary. Complex sentences can increase agitation.
- Discover what has triggered the undesirable behavior and how the patient wants the situation resolved.
  - Focus on what is causing the undesirable behavior, not the behavior itself.
  - Use active listening techniques.
    - Paraphrase and summarize, using the patient's own terminology, to ensure you understand what the patient is trying to communicate and show you are listening.
      - Don't say, "I understand," if you do not or could not understand the patient's problem.
      - Check that your understanding is accurate, for example, ask, "Can you explain what you meant by ....?"
    - Respond to what you hear in the patient's voice instead of the content, for example, say, "You sound very angry."
    - Repeat back the patient's major concerns, for example, say "You think intravenous pain medications will help you lie still for the MRI."
    - Use "minimal encouragers" (words, phrases and gestures that encourage the patient to continue and show you are listening); for example, use "OK," "I see," "go on."
  - Effectively use silence, which can encourage the patient to provide more information and can allow the patient to calm down.

- Ask open-ended questions (questions that cannot be answered with a "yes" or "no" response, and often begin with words like "How," "When," What") that facilitate your understanding of the patient's feelings and intentions, for example, ask:
  - "What is your major concern right now?"
  - "How can I help?"
  - "What can I do?"
  - "Please explain what you were expecting?"
  - "How can we make the situation better?"

- Use "I" messaging to show the patient how you feel, why you feel this way and how the patient can change to remedy the situation, for example, say, "I feel frustrated when you yell at me because I am having a hard time understanding what you are trying to tell me. I would like you to stop yelling."
- Create guidelines for the conversation, for example, say, "You mentioned Percocet is not helping your back pain and you were insulted by the radiology tech. What do you want to discuss first?"
- Find aspects of the patient's position with which you can agree.
- Reach an agreement with the patient about how the situation can be resolved.
  - Follow through with the agreement.
- Offer options for reducing agitation, for example, "We can give you a pill or a shot to help you to calm down" or, "Would you be more comfortable in an examination room?" or, "Can we start this conversation over? I feel like we got off on the wrong foot."
- Express optimism by using positive language, and avoiding words like "but," "can't," and "don't."
- If the de-escalation strategies are not effective and the patient is threatening your safety, get help, which, depending on the circumstances, might come from a colleague, security or the police.
  - Do not notify the patient that you are calling in help, as this may further escalate the patient's agitation.
- After the de-escalation, use rehabilitation strategies to direct patient behavior in the future.
  - Explain behavioral expectations and issue behavioral warnings. (A link to a sample behavior warning letter follows Case Two.)
    - Involve security, a practice manager and/or an administrator when appropriate.
  - Present the patient with a behavior agreement. (A link to a sample behavior agreement follows Case Two.)
    - Start the termination process if the patient refuses to sign a behavior agreement.
- Seek assistance for personal trauma associated with workplace violence.
- Practice de-escalation with colleagues.
- Document the encounter and future plan.

ADDITIONAL DE-ESCALATION RESOURCES

Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup
American Association for Emergency Psychiatry
Available at: ***ncbi.nlm.nih.gov/pmc/articles/PMC3298202/*** (accessed 10/30/2018)

Top 10 De-Escalation Tips
Crisis Prevention Center
Available at: ***crisisprevention.com/Blog/October-2017/CPI-s-Top-10-De-Escalation-Tips-Revisited***
(accessed 10/30/2018)

Universal Upset Patient Protocol Video
Dike Drummond, MD
Available at: ***youtube.com/watch?v=C1YsNGupQhI*** (accessed 10/30/2018)

Three Tips for Calming Agitated Patients
Jennie Byrne, MD
Available at: ***youtube.com/watch?v=z_KBnY9RK70*** (accessed 10/30/2018)

Episode 51: Effective Patient Communication – Managing Difficult Patients
Emergency Medicine Cases Podcast
Available at: ***emergencymedicinecases.com/episode-51-effective-patient-communication-managing-difficult-patients/*** (accessed 10/30/2018)

Triggers of Disruptive Behavior

Violence and agitation can be triggered by many different factors. These factors can be categorized in various ways. The list of triggers below is divided by responses to healthcare provider behavior and communication, environmental factors and symptoms of patient illness. Many times, the disruptive behavior is a manifestation of frustration due to a patient's inability to communicate wants and needs. Understanding what is causing a patient's disruptive behavior can help de-escalate it.[i]

Interpersonal Triggers

Disruptive behaviors can be triggered by what you say, how you say it and how you behave, which are often colored by the patient's interpretations. For example:[ii,iii]

What you say

- Giving the patient "bad news"
- Demanding compliance
    - Failing to offer the patient choices
- Reprimanding the patient
- Sharing confidential information about the patient with someone else

How you say it

- Being sarcastic, rude, hostile, patronizing or untruthful to the patient
- Arguing with the patient
- Interrupting the patient

What you withhold

- Denying cigarettes, food, drinks, medications
- Prohibiting visitors
- Discharging a patient who wants to stay, or holding a patient who wants to leave

How you behave

- Whispering or talking too loudly
- Speaking with co-workers in a language the patient does not understand
- Laughing
- Staring intensely at a patient
- Being inattentive
- Using negative or aggressive body language, for example, eye rolling, pointing, deep sighs, throat clearing, checking your watch, fidgeting, taking a phone call, standing in the doorway, clenching your fists, hiding your hands, folding your arms, turning away
- Getting too close to or touching a patient with physical boundary issues
- Approaching a patient with a needle or other medical device
- Showing favoritism to other patients
- Making a patient wait
- Failing to follow through with promises
- Handing off a patient to another clinician/staff member without explanation

Patient Environment

Disruptive behaviors can be triggered by the patient's environment. For example:[ii,iii]

- It is too noisy, crowded, bright, hot or cold for the patient.
- A clinician or staff member looks like someone the patient fears or dislikes or is a gender or ethnicity the patient dislikes.
- It is a triggering day (for example, a birthday or holiday) or a triggering time of day (for example, more violent events occur in the evening in the emergency department).
- The patient is restrained or secluded.

Symptoms of the Patient's Illness

Disruptive behaviors may be caused by the patient's current illness or underlying medical condition. For example:[ii,iii]

- The patient is inebriated or withdrawing from drugs or alcohol, psychotic, low functioning, autistic or suffering from dementia.
- The patient is in pain or otherwise uncomfortable.
- The patient's low oxygen saturations or oxygenation is causing an agitated state.
- The patient is suffering from medication side effects.

NOTES

i. Arnetz JE, Hamblin L, Essenmacher L, Upfal MJ, Ager J, Luborsky M. Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports. *J Adv Nurs.* 2014;71(2):338-48. Available at: **ncbi.nlm.nih.gov/pmc/articles/PMC5006065/** (accessed 10/30/2018).

ii. CSHRM. Understanding and Preventing Violence in the Healthcare Environment. [Webinar]. September 11, 2011.

iii. Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers (OSHA, 3148- 04R). 2015. Available at: **osha.gov/Publications/osha3148.pdf** (accessed 10/30/2018).

Nonverbal Cues of Imminent Interpersonal Violence

Swearing, using abusive language and threatening violence are direct indications of an impending attack, but patients may also signal they are getting ready to lash out against their healthcare team members through nonverbal communication, including:[iv,v,vi]

Body Movements

- Pacing, gesturing in an exaggerated or violent manner, assuming a boxer's stance, removing excess clothing, clenching fists, tensing the body, trembling, shaking, stretching to relieve tension, invading your personal space

Facial Expressions

- Jaw clenching, scowling, sneering

Voice Signals

- Speaking loudly, chanting, talking to oneself

Eye Contact

- Glaring or avoiding eye contact

Physiological Changes

- Flushing, pallor, sweating, extreme fatigue, rapid breathing

Of course, all of these nonverbal cues may indicate something other than imminent violence. One of the challenges of healthcare violence prevention is successfully anticipating it without unjustly profiling a patient who is not prone to violence; therefore, it is important to judge a situation by the totality of circumstances and not just on nonverbal cues.

NOTES

iv. Canadian Centre for Occupational Health and Safety. Violence in the Workplace – Warning Signs. OSH Answers Fact Sheets. Available at: ***ccohs.ca/oshanswers/psychosocial/violence_warning_signs.html*** (accessed 10/30/2018).

v. Manfredi RA, Huber JM. Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself. 2017. Available at: ***acep.org/globalassets/sites/acep/media/wellness/acepwellnessguide.pdf*** (accessed 10/30/2018).

vi. Sweet DM, Burzette RG. Development of the Nonverbal Cues of Interpersonal Violence Inventory: Law Enforcement Officers' Perceptions of Nonverbal Behavior and Violence. 2018. *Criminal Justice and Behavior*;45(4):519-540. Available at: ***doi.org/10.1177/0093854817753019*** (accessed 10/30/2018).

Terminating Treatment of Disruptive Patients

Many NORCAL Group insureds who call the Risk Management Department for advice about terminating treatment of a disruptive patient worry that it will prompt the patient to file an abandonment lawsuit or will elevate the patient's anger. The case study below is an example of a common disruptive patient scenario in an office practice.

CASE TWO

Issue: Because the patient used abusive language with the receptionist, the practice wanted to terminate treatment.

An established patient with a variety of chronic health issues called the office for an appointment. When the receptionist asked him for his date of birth, he became abusive and accused her of racial and gender discrimination; nonetheless, an appointment was made for the following week. The practice manager called the NORCAL Group Risk Management Department for advice about terminating treatment before the appointment to avoid further stress on clinicians and staff members who would have to deal with the patient during the appointment.

DISCUSSION

There were a couple of complicating issues in this case. Generally speaking, once a physician-patient relationship is established, the physician has an ongoing responsibility to the patient until their relationship is terminated. With adequate notice, terminating treatment can be appropriate and ethical. Because this practice wanted to terminate the relationship with no advance notice, the risk of abandonment had to be considered.

If this patient had presented a safety threat to clinicians and staff, immediate termination might have been appropriate. Pursuant to the Occupational Safety and Health Act of 1970 (OSHA), employers are required to provide a place of employment that is "free from recognized hazards that are causing or are likely to cause death or serious physical harm."[9] Although abandonment law is not settled in every state, a patient's threatening behavior, particularly behavior that warrants calling the police, provides a strong basis to argue that the practice owner's duty to maintain a safe office environment outweighs the duty to provide reasonable notice of treatment termination. In situations where the safety threat is either not clear or the patient's behavior is more abusive than threatening (for example, using profanity, derogatory statements, excessive or repetitive noise, offensive gestures), adequate notice is usually necessary. In this case, the safety threat to clinicians and staff was minimal. Therefore, terminating treatment of the patient without notice presented a high risk of an abandonment claim.

RISK MANAGEMENT **RECOMMENDATIONS** — REHABILITATING AND TERMINATING TREATMENT OF A DISRUPTIVE PATIENT

Preparation is the key to successfully addressing disruptive patients in office practice. Setting expectations for patient behavior at the beginning of the physician-patient relationship can signal to patients that disruptive behavior will not be tolerated. Patient "rights and responsibilities" statements or patient brochures are two ways to communicate behavior expectations. Not all disruptive patients need to be dismissed from the practice. Some patients may need a reminder in the form of patient behavior agreements or written warnings following an incident. Once a patient is informed of behavioral expectations and the consequences of violating expectations, he or she may cease being problematic. If the patient's behavior continues to be problematic, strong policies and documentation can facilitate termination of treatment in a manner that minimizes the risk that an abandonment claim will be filed. If a patient does file such a claim, evidence of policies and documentation can help successfully defend the allegation. Consider the following strategies:

- Inform patients and visitors of behavioral expectations in waiting room placards and handouts, patient rights and responsibilities statements and/or practice brochures.
  - The notice should outline the types of behavior expected and also the types of behavior for which the office has a zero tolerance policy. It should also describe the use of behavioral agreements and/or behavioral warning protocols, and the fact that patients who break the rules may be terminated from treatment.
- Create behavioral rehabilitation policies and protocols, including warnings or behavior agreement protocols, and termination policies.
  - Intervene early, before problems escalate.
  - Establish the number of times the patient will receive warnings or can violate a behavior agreement before termination may be initiated.
  - Train staff on patient behavioral policies and protocols.
- Start behavioral rehabilitation with a patient meeting to explain your expectations.
  - Clearly identify the patient's inappropriate behavior.
  - Explain why the identified behavior is not acceptable according to office policy.
  - Describe your expectations for future interactions with the patient and the consequences of the patient's failure to meet expectations.
  - Create a warning or patient behavior agreement that memorializes the expectations and patient agreement.
    - Have the patient sign and date the agreement and provide the patient with a copy.
  - Document the details of the rehabilitation encounter in the patient's medical record, including whether the patient has accepted or rejected the rehabilitation plan.
  - Communicate the rehabilitation plan and expectations to staff, along with clear directions about how non-compliant behavior should be handled and documented.

Patient Behavior Tools

Sample Patient Behavior Agreement
Regions Hospital
Available at: ***regionstrauma.org/blogs/BehavioralContract.pdf*** (accessed 11/30/2018)

Sample Patient Warning Letters
HealthPoint
Available at: ***bvcaa.org/HSPP/Clinical%20P&P/General/Warning_Letter_Abusive_Behavior_blank.pdf*** (accessed 11/30/2018)

Integrated Community Health Partners
Available at: ***ichpcolorado.com/providers/pdfs/Patient-Warning-Letter-ICHP-2013.pdf*** (accessed 11/30/2018)

Sample Patient Rights and Responsibility Language
NORCAL Group Risk Management Resource
Quality and Risk Management in Healthcare Organizations Resource Document

Termination of Treatment Resources

Termination of the Physician-Patient Relationship: Breaking Up Is Hard To Do
NORCAL Group *Claims Rx*.

Physician-Patient Relationship: Establishing and Terminating the Relationship
NORCAL Group Risk Management Resource

Service Failures and Unanticipated Outcomes

It is important to determine why a patient is angry, and whether the anger can be traced back to dissatisfaction with their healthcare experience. Terminating treatment of disruptive patients who are legitimately upset or angry because of service failures or unanticipated outcomes of treatment can increase a patient's propensity to file a lawsuit. Service recovery refers to making things right following a service failure. In a physician's office, service failures can range from long patient wait times to a patient's dissatisfaction with a treatment outcome. The nature of the event prompting the dissatisfaction should direct the response. For example, managing patient dissatisfaction due to a cancelled appointment will be different than managing patient dissatisfaction due to an unanticipated outcome of treatment. Research indicates that good service recovery and unanticipated outcome programs (such as CANDOR, see materials below) can turn a frustrated, angry patient into a loyal one who is more likely to comply with treatment recommendations and less likely to file a malpractice suit, make a report to the medical board or write a negative online review.[vii,viii,vix]

Healthcare Service Recovery Resources

There are a variety of healthcare service recovery resources available online, including:

Strategy 6P: Service Recovery Programs
Agency for Healthcare Research and Quality
Available at:
ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer-service/strategy6p-service-recovery.html (accessed 10/29/2018).

Service Recovery In Healthcare: Movement From Reactive To Proactive
The Beryl Institute
Available at: *c.ymcdn.com/sites/www.theberylinstitute.org/resource/resmgr/2015_Conference_Presentations/Pruthi.Stevens.Verness.pdf* (accessed 10/29/2018).

Fixing Healthcare Service Failures
Achieving Service Excellence. 2nd. ed.
Available at: *ache.org/pubs/pdf_excerpts/Fottler%20Excerpt.pdf* (accessed 10/29/2018).

Unanticipated Outcome and Apology Resources

Disclosure of Unanticipated Outcomes
NORCAL Group Risk Management Resource

Responding to Unanticipated Outcomes: The First Conversation
NORCAL Group *Claims Rx*

Communication and Optimal Resolution (CANDOR) Toolkit
Agency for Healthcare Research and Quality
Available at: ***ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html*** (accessed 10/29/2018).

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vii. Agency for Healthcare Research and Quality. Service Recovery Programs. 2016 Mar. Available at: ***ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer-service/strategy6p-service-recovery.html*** (accessed 10/30/2018).

viii. Pruthi S, Stevens S, VerNess C. Service Recovery In Healthcare: Movement From Reactive To Proactive. Available at: ***c.ymcdn.com/sites/www.theberylinstitute.org/resource/resmgr/2015_Conference_Presentations/Pruthi.Stevens.Verness.pdf*** (accessed 10/30/2018).

vix. AHRQ. Implementation Guide for the CANDOR Process. 2017. AHRQ website. Available at: ***ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/impguide.html#Introduction*** (accessed 10/30/2018).

Workplace Violence

According to the Centers for Disease Control and Prevention (CDC), workplace violence has reached epidemic proportions.[7] The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "the act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty."[10] Workers in healthcare settings are four times more likely to experience violence than other workers. The attacks usually come from patients or visitors.[2] Training, preparation and communication among members of the healthcare team are important aspects of workplace safety. Consider the following recommendations:[11,12]

Clinicians and Staff

- Be prepared for violence.
  - Determine the behavioral past of new or transferred patients.
  - Huddle (clinicians, nurses, risk managers, social workers, security personnel and behavioral therapists) and determine the best plan for a potentially violent patient.
  - Learn to identify predictive behaviors and common violence triggers. (See, "Triggers of Disruptive Behavior" and "Non-Verbal Cues of Imminent Interpersonal Violence" content above.)
- Share information about a patient's agitation or assaultive tendencies at handoff using patient agitation scales and/or other measures.
- Excuse yourself, leave the room or move away from the patient, and then contact security or the police if your safety is threatened.
- Alert and, when appropriate, evacuate individuals in the "zone of danger."
- Create an incident report for each incident.
  - More information about creating incident report policies and protocols is available in the NORCAL Group Resource Document entitled "***Quality and Risk Management: Incident Reporting***"

Administrators[2,6,12]

- Put workforce violence/disruptive patient behavior policies and procedures in place.
- Develop tools to help clinicians and staff identify predictive behavior and common triggers. (See, "Triggers of Disruptive Behavior" and "Non-Verbal Cues of Imminent Interpersonal Violence" content above.)
- Ensure a disruptive patient's record is flagged in a way that clinicians and staff are forewarned.
- Create behavioral response teams.
- Train clinicians and staff in de-escalation, self-defense and response to security alarms/codes/notifications.
  - Post emergency contact numbers (e.g., security and/or police) near the reception desk.
- Make the workplace safer with physical, technological and environmental strategies.
  - As necessary, consider the following: Install security cameras and security alarms, simplify exit routes, install metal detectors and barrier protections, install panic buttons in strategic locations, and control access in and out of facilities.
  - Consider partnering with law enforcement or consultants to identify potential workplace risks.
  - Prohibit clinicians and staff from working alone, particularly at night.
  - Consider whether an item a patient arrives with can be used as a weapon (e.g., a NORCAL Group insured was attacked with a bicycle seat).
  - Survey your facility to determine whether there are items accessible to patients that could be used as weapons (e.g., NORCAL Group insureds have been attacked with various items patients found in treatment areas, including a pipe that was unscrewed from a toilet, a fire extinguisher and an IV pole).

  - Survey your facility for areas that may pose an opportunity for assault or hostage-taking, such as empty hallways, unlocked storage areas or separated work areas.
- Treat known aggressors in relatively open, easily accessible areas that still reasonably maintain privacy (e.g., rooms with removable partitions).
  - Consider having more than one person in the room if an easily accessible area is not available.
- Review each incident of workplace violence.
  - Debrief with involved individuals following an incident.
    - Create risk management strategies based on what is discovered.
- Develop a comprehensive plan and provide accessible, effective support for all clinicians and staff experiencing workplace violence.
- Conduct risk assessments regularly to evaluate preparedness for workplace violence.
- Put systems in place that facilitate workplace violence reporting.
  - Notify leadership, security, law enforcement and state authorities as necessary, pursuant to workplace violence regulations and guidelines.
- Provide support for clinicians and staff who are involved in or witness workplace violence.

Additional Workplace Violence Resources

Sample Disruptive Patient Policy
California Hospital Association
Available at: ***calhospital.org/sites/main/files/file-attachments/disruptive_behavior_guidelines.pdf***
(accessed 10/30/2018)

Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
OSHA
Available at: ***osha.gov/Publications/osha3148.pdf*** (accessed 10/30/2018)

Sample Protocol for Reporting Workplace Violence
Western Connecticut Health Network
Available at: ***jointcommission.org/assets/1/6/wchn_Assault_WCHN_Employee.pdf*** (accessed 10/30/2018)

Workplace Violence Prevention for Nurses Course
CDC
Available for continuing nursing education credit at: ***cdc.gov/niosh/topics/violence/training_nurses.html***
(accessed 10/30/2018)

Debriefing Strategies Webinar
Crisis Prevention Institute
Available at: ***youtu.be/-Z41xcAqPm4*** (accessed 10/30/2018)

Behavior Documentation Toolkit
The Provincial Violence Prevention Steering Committee of the Occupation Health & Safety Agency for Healthcare in British Columbia
Available at: ***phsa.ca/Documents/Occupational-Health-Safety/ToolkitOHSAHBehaviourDocumentationtoolkit.pdf***
(accessed 10/30/2018)

Tools to Measure, Track and Communicate Patient Agitation

- Agitated Behavior Scale — form and directions available at: ***fpnotebook.com/Psych/Exam/AgtdBhvrScl.htm*** (accessed 10/30/2018)
- Behavioral Activity Rating Scale — form and directions available at: ***ucdenver.edu/academics/colleges/medicalschool/departments/psychiatry/Research/Documents/Simpson/CJPP_2017.pdf*** (accessed 10/30/2018)
- Cohen-Mansfield Agitation Inventory. Available at: ***pdx.edu/ioa/sites/www.pdx.edu.ioa/files/CMAI_Manual%20%281%29.pdf*** (accessed 10/30/2018)

CONCLUSION

Disruptive patient encounters are inevitable. They are risky from a worker safety, patient safety and professional liability standpoint. Successful management of an incident depends on developing the skills necessary for recognizing risks and keeping everyone safe. Successful disruptive patient management also requires follow-up policies and protocols that minimize liability risk and protect clinician and staff well-being following an incident. Many disruptive patients are simply responding to unmet needs or expectations. It is incumbent upon clinicians and staff to adjust problematic patient expectations, discover what has triggered the patient's unacceptable behavior, solve the problem when possible or offer alternatives when appropriate. Although termination of the relationship with a disruptive patient may be the easiest way to follow up an incident, if the behavior is the result of dissatisfaction, in many cases the better strategy is to understand the patient's complaint, empathize, apologize and then re-establish behavioral expectations for moving forward in the physician-patient relationship.

ENDNOTES

The NORCAL documents referenced in this article, along with many other Risk Management Resource documents and past editions of the *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855.882.3412.

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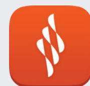

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