BMH Challenging Patient Behavior and Discharge Guidelines:

Patients admitted to the BHCHP respite facilities often have a significant history of trauma and distrust in the medical field. We will make every attempt to involve the interdisciplinary team when there is concern that the patients' behaviors may make it difficult for them to stay in respite.

In writing guidelines for patient behavioral management, we must acknowledge that this is a medical facility and that **patients have varying degrees of medical need to remain in respite**. This medical need will be weighed in determining the supports that will be put in place to allow for a patient with challenging behaviors to remain in respite.

We also want to recognize that difficult patient behaviors **have an impact on the wellness of the milieu, as well as the safety of other patients and staff.** Therefore, the risk associated with difficult patient behaviors will also be weighed in determining what behaviors can be accommodated in respite and for how long.

As a program, we recognize that substance use is part of a disease process, and while we do not condone the use of illicit substances within the facility, we accept that it occurs. We will do our best to improve the safety and outcomes of patients who are actively using while in respite. We will attempt to decrease the stigma of patients who are using, as well as **minimize confrontations** with staff by utilizing these guidelines to manage challenging behaviors.

We will not punish patients for drug use or sedation but recognize some behaviors that manifest from this disease process can be triggering for other patients, as well as challenging for staff. Therefore, we have action plans for SUD related behaviors.

We have developed a workflow for managing behaviors and risks in respite which is outlined in this document and follows the steps of a general risk management scheme.

BMH definition of a risk (challenging behavior):

We have divided patient behaviors into 2 categories, those that cause an immediate safety risk, and those that do not.

Immediate Safety Risk: Patient behaviors that create an unsafe situation or environment for staff, other patients, or the overall milieu.

Any patient causing an immediate safety risk to themselves, or others, can be immediately discharged at the discretion of the involved staff. If leadership is available, they will be notified as soon as possible that there is a patient posing an immediate safety risk.

Behaviors that pose an immediate safety risk may include:

- Physical harm to staff
- Threats to patients or staff that are **determined to be High Risk**
- Possession of weapons or non-weapon items with the intention of using them as weapons
- Significant disruption to the milieu that is unable to be redirected with appropriate therapeutic intervention.

- Sexual assault or significant harassment to staff or patients

Any time that it is safe to contact the medical team prior to the determination to discharge, they should be consulted.

Non-Immediate Safety Risk: Challenging behaviors that are disruptive and difficult to sustain in respite, however there is no immediate threat to staff, other patients, or the overall milieu.

Challenging behaviors that do not pose an immediate safety risk may include:

- Behaviors around substance use
- Sexually Inappropriate Behavior (excluding those that are grounds for immediate discharge)
- Challenging Patient Communication
- Difficulty Engaging in Care
- Unsubstantiated threats of violence
- Altercations between patients, in which patients or staff are not at immediate risk of harm.
- Derogatory language

Behaviors related to substance use:

When reporting these actions, it will be important to highlight the challenging behavior, as opposed to suspected offense. (Ex: "We have seen John Smith in room 408 multiple times today. That ongoing behavior can be grounds for discharge" as opposed to "We think John Smith is distributing).

Sedation:

Patients who are sedated can be brought to the CAT room for monitoring. **If recurrent sedation is a barrier to the patient engaging in care** related to the goal of their respite admission, the team will discuss more appropriate levels of care for the patient (ex: detox). **If sedation is creating concerns for safety,** the team will discuss discharge to the emergency department.

Possession of Illicit Substances or Paraphenalia:

A patient found with items not allowed in respite will be given the opportunity to allow staff to **dispose** of them and to remain in respite, or to discharge from respite **with their property.** Please feel empowered to take the substance/paraphernalia in the moment, rather than report it and wait for leadership. We have learned that room searches are not typically fruitful, and it is best to address these incidents when they are witnessed.

Entering other patient rooms:

For the comfort and safety of all respite patients, patients are not allowed to go into rooms that are not their assigned room. For the first incidence of this behavior, patients will receive a **verbal redirection** from floor staff (charge, team nurse, provider, etc.). If the behavior continues after a verbal redirection is given, **an incident report** will be submitted to leadership to further discuss the patient. Persistence of this behavior will be considered for discharge per the non-immediate safety risk protocol.

Staff witnessed interchange:

For the comfort and safety of all respite patients, patients are not allowed to sell items to one another (cigarettes, illicit substances, etc.). If a staff member witnesses an interchange of items between patients, an **incident report** will be submitted. No verbal redirection will be issued for the first instance to avoid stigmatizing patients. Leadership will track these incidents and if the behavior is accompanied by other challenging behaviors and/or interchanges persist, a conversation will be had with the team and patient will be considered for discharge per the non-immediate safety risk protocol.

Respite Misconduct:

Leaving the building or returning from appointments late/ on own:

For the safety and well-being of all respite patients and staff, respite patients are **only** permitted to leave the building for approved scheduled appointments and must use BHCHP arranged transportation to and from **all** appointments. For the first incidence of this behavior, a **verbal redirection** will be issued by the Charge Nurse or Nurse Manager and an **incident report** will be submitted to alert respite leadership. Persistence of this behavior will be considered for discharge per the non-immediate safety risk protocol.

Non-compliance with medical care:

All patients admitted to respite should have a medical goal established on admission and are expected to engage in medical care as a part of the daily respite routine. Medical care includes compliance with required vital signs, medication administration, as well as labs, wound care, and finger sticks when applicable. Patients do, however, have the right to decline care. If a patient is declining care, please ensure you are documenting defensively. For the first incidence of this behavior, a **verbal redirection** will be issued by the Team Nurse or Charge Nurse. If the behavior continues after a verbal redirection is given, **an incident report** will be submitted to leadership to further discuss the patient, and the Team Nurse will bring this up for discussion huddle. Persistence of this behavior will be considered for discharge per the non-immediate safety risk protocol.

Challenging patient communication:

All patients admitted to respite are expected to treat staff and other patients with dignity and respect. Examples of disrespectful patient behaviors may include swearing at staff or other patients, raising voice to staff or other patients, aggressive gestures to staff or other patients. For the first incidence of this behavior, a **verbal redirection** will be issued by the Team Nurse or Charge Nurse. If the behavior continues after a verbal redirection is given, **an incident report** will be submitted to leadership to further discuss the patient. Persistence of this behavior will be considered for discharge per the non-immediate safety risk protocol.

If a patient uses derogatory language towards staff or another patient, an incident report will be submitted to leadership to further discuss the patient. This behavior will be considered for discharge per the non-immediate safety risk protocol.

If a patient makes threatening comments to staff or another patient, behavioral health and leadership should be alerted. An assessment will be performed to determine the substantiation of the threat. This behavior will be considered for discharge per the non-immediate safety risk protocol.

Smoking in bathrooms/rooms:

For the safety and well- being of respite patients and staff, patients are not allowed to have lighters on the respite floors, and most smoke on the smoking deck at designated breaks. If a patient is smoking on the floor, a **verbal redirection** will be issued by the Charge Nurse for the first incidence. If the behavior continues after a verbal redirection is given, **an incident report** will be submitted to leadership to further discuss the patient. Persistence of this behavior will be considered for discharge per the non-immediate safety risk protocol.

Respite routine misconduct:

All patients admitted to respite are expected to follow the respite routine. The respite routine is established on admission, both in the BMH Welcome Packet, and by the admitting nurse. For the first incidence of this behavior, a **verbal redirection** will be issued by the Team Nurse or Charge Nurse. If the behavior continues after a verbal redirection is given, **an incident report** will be submitted to leadership to further discuss the patient. Persistence of this behavior will be considered for discharge per the non-immediate safety risk protocol.

The following is a generalized risk assessment workflow used to inform how we will manage behaviors and risks in respite:

Risk Assessment → allows decision makers to determine, based on identified and analyzed risks, which risks will be treated and with which priority.

- **Consists of 3 phases:**
  - **Risk Identification** → used to find, recognize, and describe the hazard that could affect the achievement of objectives.
  - **Risk Analysis** → to understand the nature, sources, and causes of the risks identified and to **estimate the level of risk**.
    - We are implementing two **Risk Assessment Tools** to assist with this process.
    - To assess **risk to the patient** based upon their need to be in respite: **DMRA**.
      - A risk matrix method, also called "decision matrix risk assessment (DMRA) technique", is a systematic approach used in the risk assessment process to determine and to rank the risk level, which level depends mainly on two variables: **severity of harm and occurrence probability of this harm or likelihood.**
    - To assess risk to self, other patients, and staff: **MOAS**
      - The Modified Overt Aggression Scale (MOAS) is a four-part behavior rating scale used to document the frequency and severity of aggressive/challenging episodes.
  - **Risk Evaluation** → used to compare risk analysis results (assessment tools) w/ risk criteria (guidelines) to determine whether a specified level of risk is acceptable or tolerable and identifying where additional action is required.
- **Risk Treatment**
- **Communication**
- **Monitoring and Review**

Step by Step Workflow for managing challenging patient behaviors in respite:

If the patient requires an IMMEMDIATE discharge due to an imminent safety risk, the following steps may not be able to occur, but should be attempted when possible.

1. **Identify risk/ challenging behavior.**

- Risk to be identified per above guidelines. Immediate safety risks vs. non-immediate safety risks.
- If the behavior is determined to be an **immediate safety risk → immediate administrative discharge** is appropriate.
    - Any patient(s) who is causing an immediate safety risk to themselves or others can be immediately discharged at the discretion of the involved staff. If leadership is available, they will be notified as soon as possible that there is a patient(s) posing an immediate safety risk.
- If the behavior is determined to be a **non-immediate safety risk** → continue to step 2.

2. **Per guidelines, issue a verbal redirection and/or submit incident report to respite leadership.**

- Incident reports will be reviewed every weekday morning, and leadership will designate a representative to follow up with the patient and appropriate team members.
    - Reports will also be filed in the leadership office, therefore repeat behaviors can be tracked without documenting in the patient's electronic medical record.
    - An e-mail will be sent after each report is followed up on to close the loop and communicate with the appropriate people.
- Challenging behaviors should also be discussed in an interdisciplinary huddle.

3. **Risk analysis**

- When applicable. risk assessment will be performed to evaluate the risk of discharge to the patient vs. the risk of keeping the patient in respite.
    - Clinical risk to patients will be assessed using a decision matrix risk assessment and risk to safety to others will be assessed using the modified overt aggression scale (see attached).
    - Scores to be compared if both scales are required to make a decision. Patients who score less than 4 on the DMRA, can be discharged expeditiously. Patients scoring 5-12, should be discharged as soon as a safe discharge plan can be put in place. Patients scoring 15-25 will require additional supports to remain in respite until there is a change in score or situation.
    - If their MOAS score is greater than their DMRA score, the patient will be discharged. If the patient's MOAS score is greater than 9, the patient will be considered for discharge regardless of their DMRA score.
        - Team provider or medical director on call should perform DMRA to determine medical risk to patient.
        - Behavioral health to perform MOAS. In absence of behavioral health, nurse manager can perform.
    - If the patient is deemed to be unsafe to discharge from a medical or psychiatric standpoint, please refer to the section in supporting patients in respite with challenging behaviors.

4. **Risk Treatment**

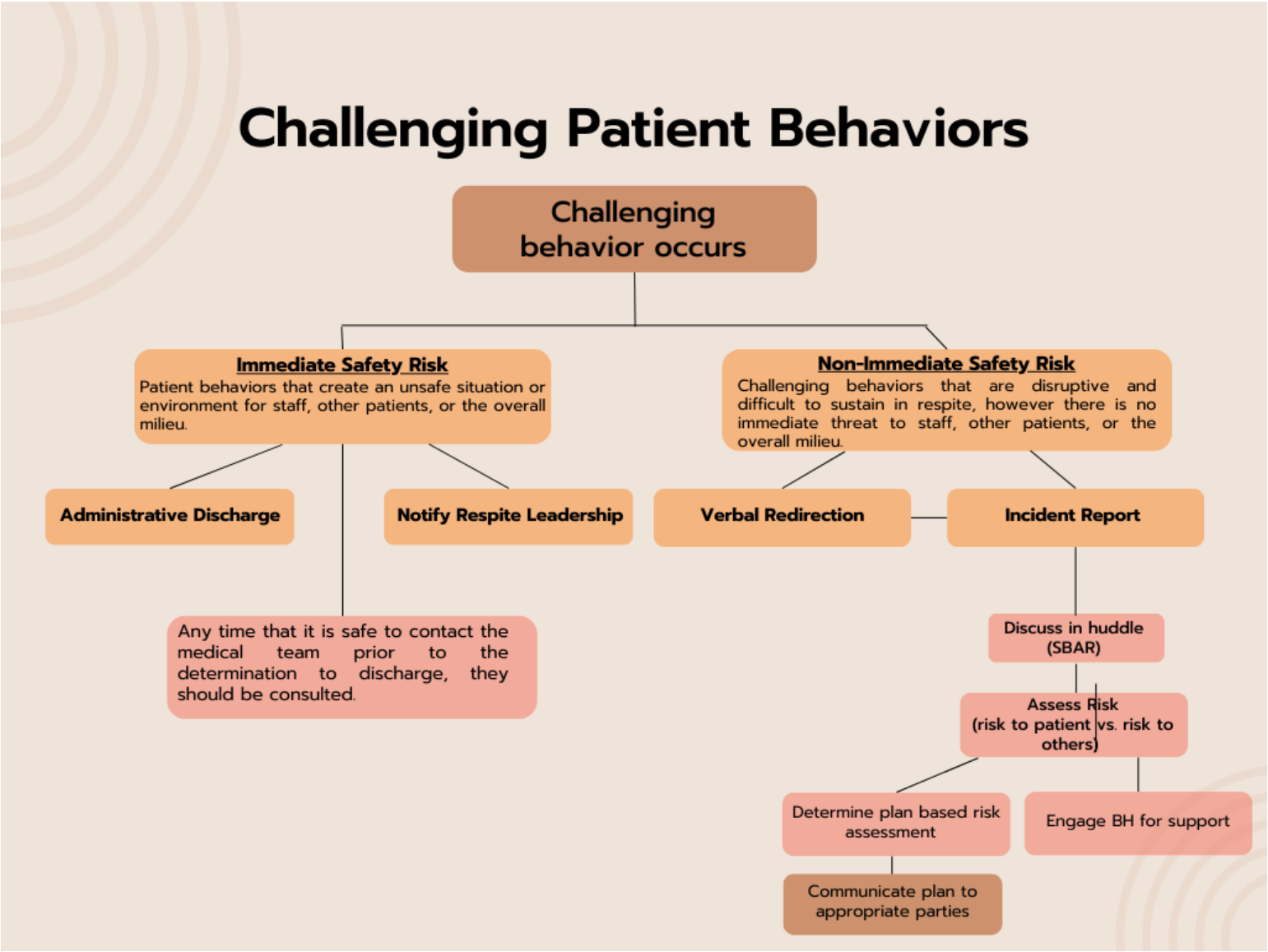
- A plan will be put in place to support challenging patient behaviors and communicated with appropriate staff.

- Recurring challenging behaviors will prompt the medical team to put a contingency plan in place.
    - Contingency plans will be set up for patients at high risk of administrative discharge and for BOLT patients at their first team rounds during their stay.
- Persistent challenging behaviors will be considered for discharge per the non-immediate safety risk protocol.

5. Monitoring and Review

- For imminent safety risks that require immediate discharge, or persistent challenging behaviors that will be considered for discharge:
    - Check in with the medical team to determine if the patient can safely discharge (when possible)
    - Check for urgent discharge contingency plan in Respite Care Summary.
    - Inform the case manager of impending discharge.
        - Reach out to the outpatient team (if applicable) to put community support in place when possible.
    - Send e-mail to CRIT list if patient is eligible for a restriction/ readmission criterion when returning.

The following flow chart demonstrates how challenging patient behaviors should be managed:



Additional considerations when a patient is having a behavioral issue:

- Refer to BH for support.
- Request to join the Length of Stay meeting and discuss discharge plans for patients that pose challenging discharges.
- Consider interdisciplinary team meeting to create a behavioral management plan, contingency management plan and expediting a safe discharge plan to a more appropriate level of care. Contingency plan to be made with leadership support and implemented by the interdisciplinary team.

Discharge Planning Starting on Admission:

- When a patient is admitted the provider will assess where the patient is coming from and where they might go upon discharge. The provider will set an estimated date of medical stability when possible.
- Medical team will consider adding contingency plans to reference in the event of the need for an urgent and unplanned discharge.
    - Contingency plans will be set up for patients at high risk of administrative discharge and for BOLT patients.
- In patient rounds, the team will discuss possible discharge options and when appropriate, set discharge dates,

Treatment Program Referrals:

- Treatment program expectations are outlined in the Treatment Program Contract that is reviewed by the treatment program specialist.
- Patients will be able to stay at BMH for up to 2 weeks following medical stability if they are adhering to the standards as outlined.
- Patients who are actively using will be referred to BH, treatment program coordinator will be notified of concerns and patients will be offered the appropriate level of care.