III.

Seven Steps to Management of Disruptive and/or Abusive Behaviors
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A. Examples of Unacceptable Behavior

- **Verbal actions:** use of obscenities, use of curse words, shouting, screaming, name calling, racial or derogatory remarks, and sexual/suggestive remarks.

- **Physical actions:** actual or perceived violent/threatening behavior, throwing of objects, hitting staff, yanking out needles, blood spray, spitting, abuse of drugs and/or alcohol, pinching, slapping, touching staff inappropriately, stalking.

- **Threats:** Written or verbal. Display of or threat to use a weapon. Remember that the patient must have a means and motive for carrying out a threat should you consider the patient to be an immediate threat and are considering an immediate discharge.

- **Interference with facility operations:** unauthorized visitors; manipulation of dialysis machines; slanderous and/or libelous statements regarding staff, the operation of the facility, or other patients in the facility; destruction of equipment; trespassing into unauthorized areas.

B. Patient Centeredness

The Conditions for Coverage addressed the specific requirement of assessing the patients’ psychosocial status in §494.80 Condition: Patient assessment. The Interpretive Guidance v510 provides a list of psychosocial criterion that must be assessed by the facility Social Worker. This list includes **but is not limited** to the following:

- Cognitive status and capacity to understand;
- Ability to meet basic needs;
- Ability to follow the treatment prescription;
- Mental health history, capacities, and needs for counseling;
- Substance abuse history, if any;
- Current ability to cope with and adjust to dialysis;
- Expectations for the future and living with kidney failure and treatment;
- Educational and employment status, concerns, and goals;
- Home environment including current living situation;
- Legal issues (e.g., court appointed guardian, advance directive status, and health care proxy);
- Need for advocacy with traditional (nursing home) and non-traditional housing (e.g., homeless shelters, group homes);
- Financial capabilities and resources;
- Access to available community resources; and
- Eligibility for Federal, State, or local resources.

Patient assessments must be completed within 30 days (or 13 treatments) from date of admission to the facility. Using the entire assessment period will offer the Social Worker a chance to better understand the patient and begin to explore what types of interventions are needed for the patient. Facility Social Workers are encouraged to utilize the KDQOL as a means to fully assess their patients and develop an individualized Plan of Care.

Having a philosophy of patient centeredness is the basis for effective communication during challenging situations. Remember the importance of taking a holistic or all encompassing view of your patients. Consider the
following concepts when disruptive behaviors emerge:

- How has the patient adjusted to his/her diagnosis with ESRD?
- Has your patients’ employment/education status become affected by dialysis treatment?
- Has your patient recently lost benefits due to loss of employment and is now receiving government aid? How has he/she adjusted to this dependency?
- What are the coping skills that the patient has developed in order to cope with ESRD?
- Are there maladaptive behaviors and coping skills?
- Does the patient express his/her frustrations with ESRD through anger?
- Has the patient turned to drugs and/or alcohol to cope with ESRD?
- Is the patient mildly or severely depressed?
- Has the patient expressed any suicidal ideation regarding the diagnosis?
- Does the patient have a severe and persistent mental illness? Treated or untreated?
- Is the patient aging and developing signs of Dementia or Alzheimer’s disease?
- Have you considered that the patient is in need of End-of-Life counseling?

During any difficult situation with the patient, staff can become frustrated, tired, fed-up, etc… Having effective tools to de-escalate challenging situations is critical in sustaining a collaborative relationship with the patient. ESRD Network 18 encourages facilities to explore techniques such as Motivational Interviewing, Recovery Model training, Wellness Recovery Action Planning, Strength Based Training and Core Gift Training. These trainings are specifically designed to address the mental health and psychosocial needs of individuals while emphasizing the strengths each patient possesses.

C. Policy Regarding Disruptive/Abusive Behaviors

Each dialysis facility should have a written policy regarding management of disruptive and/or abusive patient behavior.

- The policy should address the specific behavior of the patient, and their family/friends on the entire premises of the dialysis facility, not just inside waiting room and treatment area.
- The policy should include steps to be taken in the event of threatening or violent behavior. This should include but not limited to, letters of concern, Care Conferences, consultation with ESRD Network 18, Agreement of Expectations, Behavioral Contracts, In-Service trainings, etc…
- The policy should prohibit patients and staff from carrying weapons and the facility will post “No Weapons Allowed” signs on its doors. The policy should also include steps the facility will take if weapons are brought into the facility i.e. contact local police authorities.
- The policy should address the guidelines not to initiate treatment, to terminate treatment and/or terminate the patient relationship for abusive/violent patients.
- All staff should receive orientation and continued education to ensure that these situations are handled appropriately and consistently.
D. Agreement of Expectations

Dependent upon the severity of the patient’s behavior, initiate an agreement of expectations with the patient as a possible first step in management of their behavior. A positive patient-facility relationship is necessary for efficient and effective treatment. Open, ongoing, two-way communication is the core of a healthy patient-facility relationship. Clearly defined expectations between the patient and the dialysis facility can provide a foundation for preventing conflict and challenging situations. The Agreement of Expectations should specify:

- The patient’s expectations of the facility and treatment team.
- The facility’s expectations of the patient and family members/significant others if applicable.
- Specific actions to be taken when one or the other is not met.

A sample Agreement of Treatment Expectations is attached as Appendix C. It is recommended that the Agreement of Expectations be reviewed at each patient care conference or as needed. If the patient’s behavior becomes disruptive, a more specific behavior contract may be developed for the patient.

If you are admitting a patient that has previously been involuntarily discharged from a facility we suggest that you allow the patient the 90 day assessment period to become oriented to the new facility. Placing a patient on an agreement/contract upon admission may create an atmosphere for the patient to feel that he/she is being set up to fail. Allow the patient to make a fresh start. Should the patient demonstrate similar behaviors/issues that led to the previous transfer/discharge, consider establishing an Agreement of Expectations at this time.

E. Rules of Conduct

Written rules of conduct for patients and staff should be established in each facility. When setting these rules, it is important to keep in mind that:

- These rules apply to all patients at all times.
- All staff must enforce the rules with all patients uniformly and consistently.
- All staff should be able to explain the purpose of all rules to patients and family members.
- Rules of conduct should indicate intolerance for violence and threats of violence. Providing examples of what this looks like helps to lessen subjectivity and provides behavioral anchors to reference.
- Patients should be informed that verbally abusive or threatening behavior is unacceptable and may lead to involuntary discharge.

F. Team Meeting to Develop a Plan of Action

Even with an Agreement of Expectations in place, problems may occur. The interdisciplinary team should arrange a conference with the patient to discuss the behavioral concern and develop a plan to resolve it. The patient should be classified as “unstable” at this point. Any plan is often reviewed in 30 days which is stated in the guidelines for re-assessing a patient that is classified as “unstable.” Please refer to v520 of the Conditions for Coverage Interpretive Guidance. Members of the interdisciplinary team should at least include the patient, patient’s physician or the medical director, the social worker, the nurse manager and, if necessary, the administrator. A family member or patient’s representative, HMO renal case manager, and others should also be included if appropriate. If your patient is receiving mental health treatment and is assigned a Case Manager/Social Worker/Therapist, it would be beneficial to invite this person to attend the Care Conference as well.
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During this meeting the staff and patient should:

- Identify specific problems and behaviors. Be sure to distinguish behaviors from symptoms of a possible mental illness.
- Identify contributing psychosocial factors.
- Identify possible solutions.
- State the clear expectations of the patient, facility and staff members.

Follow up the meeting with a letter to the patient summarizing the outcome of the meeting and what is expected of him/her and what they can expect from the facility. A written plan to correct the problem should be developed and signed by the patient and staff. The patient care staff should be informed of the plan to be used in dealing with the specific behavior(s). Thorough documentation of the specific behavior(s) that are being displayed and the steps taken to correct the problem is essential.

The following suggestions may enhance the chances for a successful outcome of the team meeting:

- The meeting should be planned in advance and well thought out. Having an impromptu meeting chair side may end in the patient feeling ganged up on and defensive. Allow the patient a chance to invite who they feel should attend this meeting.
- All participants should understand and agree on the purpose and desired outcome of the meeting. Allowing the patient an opportunity to participate in the development of goals for the meeting will provide the patient with a feeling of inclusion and may create a greater opportunity for collaboration.
- Staff members attending the patient conference should meet in advance to discuss all aspects of the meeting as well as the primary objective of the meeting.
- Approach the meeting with a calm and positive attitude.

The purpose of the meeting is not to “threaten” the patient into behavioral compliance but to gain information, provide information, and find a way to work together for the patient’s well being.

G. Behavior Agreements or Agreement Expectations

A patient behavioral contract may be a very useful corrective action tool. The purpose of this document is to define behavior(s) that must change if a patient wishes to continue dialyzing at the facility. It is a tool that should be used only after the patient has been previously educated, counseled on his/her behavior(s), and did not meet the conditions of the Agreement of Expectations. Please note that a breach in the behavioral contract is not automatic grounds for an Involuntary Discharge. The contract is meant to be a tool geared towards resolution.

If the problem continues, the treatment team (including the HMO renal case manager, if applicable) should meet with the patient one more time. A family member or patient representative should be invited to attend. The team and the patient should try again to identify possible reasons for the continuing behavior(s) and potential solution(s). A behavioral contract should be developed which outlines specific patient and staff responsibilities related to the specific behavior(s) identified and the potential consequences for detouring from the agreed upon expectations. Consider including a psychiatric evaluation (or alternate care from an appropriate mental health care professional) in the agreement. The behavioral contract should be a written document containing the following:
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- A clear description of the problem behavior and why it is unacceptable;
- The expectation for improvement of the patient’s behavior;
- Responsibilities of the dialysis staff to the patient;
- Timeline(s) for improvement;
- Action(s) that will be taken if the timeline(s) are not met; what will these actions look like i.e. another Care Conference;
- A statement that the patient’s continued negative behavior may cause the dialysis facility to begin the involuntary discharge process, and when it may begin;

The patient, the physician, and a facility management representative should sign the agreement. If the patient refuses to sign the agreement, a witness should co-sign with documentation that the patient had refused. Offer a photocopy of this contract to the patient.

When establishing timelines, a minimum of 30 days should be allowed for the behavior to improve. The patient should be classified as “unstable” if he/she is not already classified as such.

Meetings with the patient should be scheduled during non-dialysis times and with consideration to the patient’s availability.

All proceedings involved in instituting the behavioral contract should be documented and kept as a part of the patient’s medical record.

Follow up in writing to the patient after the Care Conference and development of the contract. Remind the patient in this letter what was agreed upon and the facilities appreciation for cooperation and collaboration.

When considering a behavior contract please be sure to notify and consult with your legal department/risk management.

When developing the behavioral contract, consider developing this contract with the input of the patient. Having a boiler plate contract does not individualize the behaviors specific to the patient and does not allow for collaboration between the patient and the facility. It is understood that patients often demonstrate similar behaviors in the unit. However, the root causes for the behaviors are very specific and unique to the patient. Remember that the goal is to establish a plan for change. Patients will more likely agree to the plan if they are a part of the development and feel included. Please note that a violation of the agreed upon actions in the behavioral agreement does not automatically result in the Involuntary Discharge of a patient.

H. Involuntary Discharge

If all forms of intervention have been exhausted, the facility may decide to end the facility-patient relationship. This should only occur as a last resort in resolving the situation. Before proceeding, the facility should have the following documentation in the patient’s medical record, in accordance with the Conditions for Coverage §494.180 (f):

- **Document** in the patient’s medical record the ongoing and specific behavioral problem.
- **Document** the impact of behavior on other patients/staff/facility, if any.
- **Document** all steps the facility has taken to resolve the problem (including behavioral contracts, patient/staff meeting, letters of concern, etc.).
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- **Document** patient’s response to each step taken and the reassessment of the situation.
- Once patient is a potential or an At-Risk for discharge the patient is considered unstable and comprehensive assessment is done monthly \((v520)\).
- Notify the Network of the potential IVD.

**Final Steps**

When the decision to involuntarily discharge has been made, the following steps must be taken:

- Notify Network 18 of the decision to initiate the 30 notice to discharge.
- Contact other facilities, attempt to place the patient when the 30-day notice has been given, and document your efforts.
- Obtain a written physician’s order signed by both the medical director and the patient’s attending physician agreeing with the patient discharge.
- In cases of immediate severe threats to the health and safety of others, the facility may use an abbreviated procedure. (Only one physician signature is required on the physician order, placement in another facility is not required, and follow the remaining guidelines.)
- Notify the State Survey Agency of the involuntary discharge and document it in the medical record that you have done so.
- Report the patient as an IVD \((6c)\) in the monthly PAR.
- Provide the patient with a 30-Day notice of the planned discharge (If it is not an immediate discharge).
- The facility should inform legal counsel of the decision to involuntarily discharge and the reason(s) for it.
- Assure the patient that the facility will continue to provide treatment up to the termination date period, unless patient behavior warrants immediate discharge.
- Provide a list of facilities for the patient to contact for placement if placement has not been coordinated prior to discharge.
- Emphasize to the patient the importance of finding another facility and/or physician for continued care.
- The Administrator/Medical Director should ensure that all steps taken are consistent with federal regulations, state law, and corporate/facility policy.

Once a facility decides to involuntarily discharge service to a patient, the physician may or may not decide to discharge the patient from his/her service. If the physician decides to end his/her relationship, a separate letter should be written to inform the patient. This letter should include the last date of treatment, specific reason(s) for ending his relationship with the patient, and a list of other nephrologists and phone numbers for the patient to contact. If physician decides to *keep* the patient he/she is assuming partial responsibility for placing the patient in another facility where he/she has admitting privileges.

**Immediate Discharge**

Patients may be involuntarily discharged immediately from the physician and/or dialysis facility if their behavior(s) endangers the safety of staff or other patients. It is imperative that facility policy stipulates specific behaviors that will be grounds for immediate involuntary discharge. The facility may notify the patient verbally but should follow-up with written documentation. Patients must be made aware of this policy during initial orientation and subsequently as appropriate. The facility should send a letter by same-day service/ overnight delivery and via regular mail, or contact the patient by phone.
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Per the CIC Interpretive Guidance: An “immediate severe threat” is considered to be a threat of physical harm. For example, if a patient has a **gun or a knife** or is **making credible threats of physical harm**, this would be considered an “immediate severe threat.” **An angry verbal outburst or verbal abuse is not considered to be an immediate severe threat.** In instances of an immediate severe threat, facility staff may utilize “abbreviated” involuntary discharge or transfer procedures. These abbreviated procedures may include taking immediate protective actions, such as calling “911” and asking for police assistance. In this scenario, there may not be time or opportunity for reassessment, intervention, or contact with another facility for possible transfer. After the emergency is addressed and staff and other patients are safe, staff must notify the patient’s physician and the medical director of these events, notify the State Agency and ESRD Network of the involuntary discharge, and document this contact and the exact nature of the “immediate severe threat” in the applicable patient’s medical record.

What does credible mean? A credible threat may be considered if a person brings in a knife, begins waving it around and says that he/she is going to stab someone. If a patient has a known violent history whereby he/she has acted upon previous threats, this may be considered a credible threat. A patient with a “criminal background,” without knowledge of what crimes have been committed, does not automatically insinuate that he/she has a violent background and will act upon a threat. Knowing that the patient has the means and motive to carry out a threat may be considered a credible threat. A patient saying “I’m going to get you” is not necessarily a threat that may be acted upon.

If the facility elects to immediately discharge a patient, the facility should follow all of the guidelines detailed in final steps except that the patient will be notified that the discharge is immediate, no further treatment will be provided.