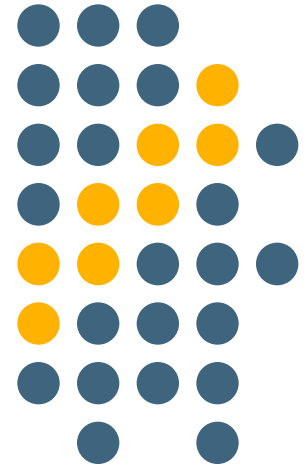


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# Code White Review



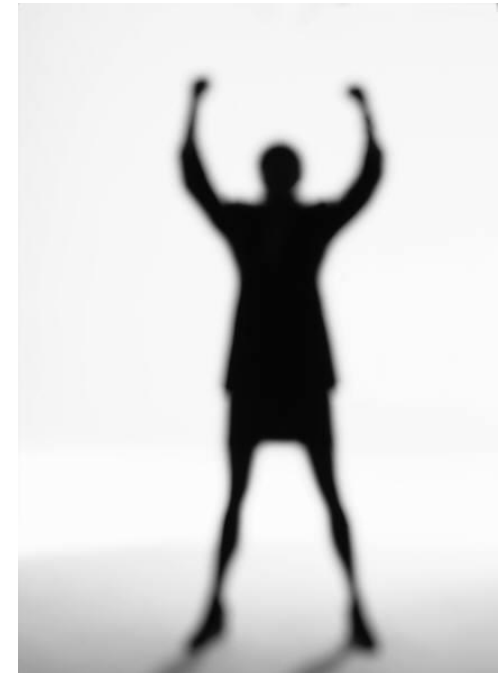
Adult Mental Health, LHSC

Draft v.1 Sept 1/15



# Code White Review

- **Introduction**
- The initiation of a Code White represents a psychiatric/mental health emergency
- Mental health care professionals, security and hospital staff are alerted to the fact that a violent episode is in progress
- A coordinated effort is needed to bring about a safe resolution of the situation.



# Learning Objectives



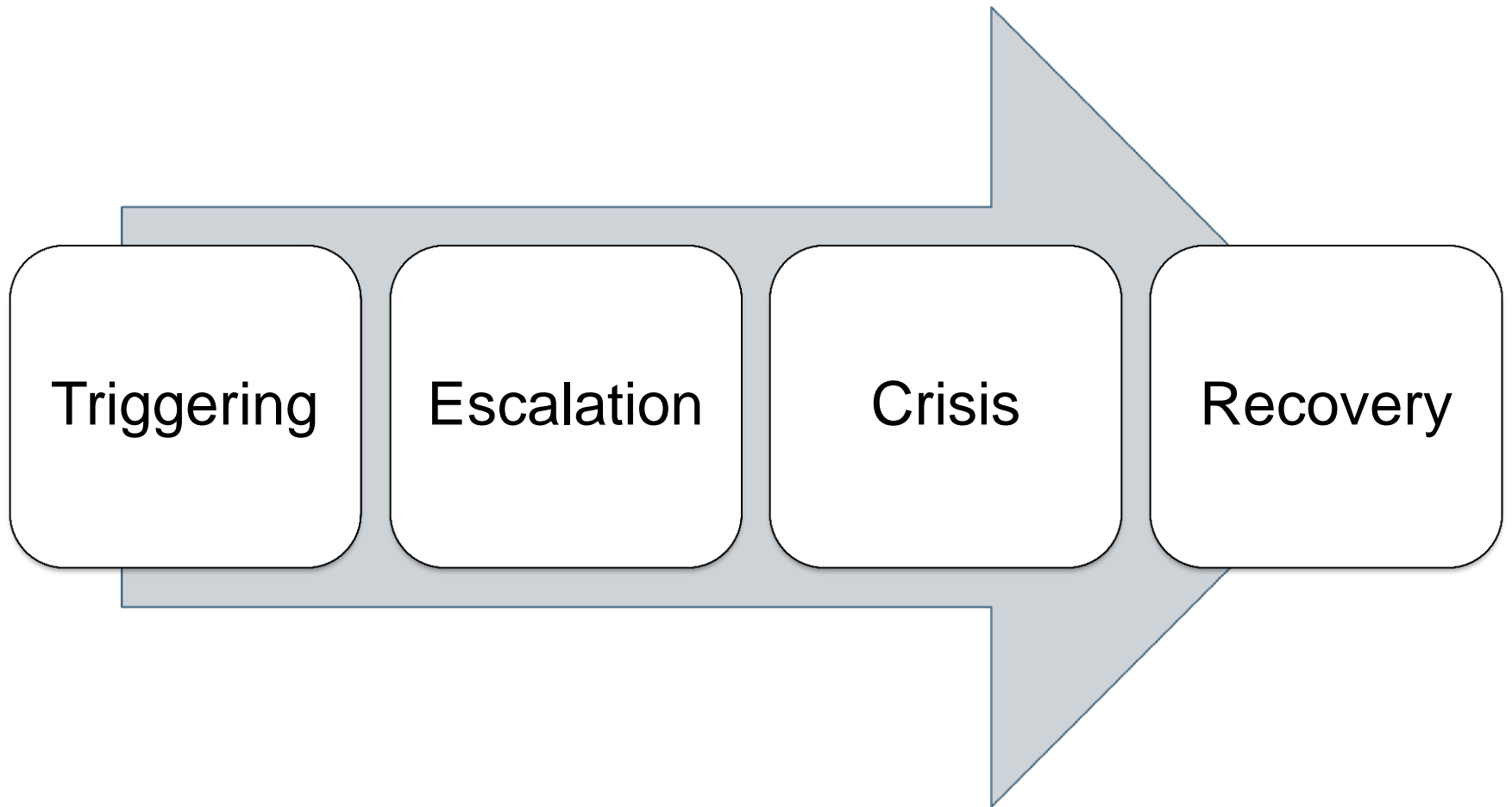
- Identify the stages leading to violence to the extent that the stages are mapped and one key emotional/behavioral feature is highlighted for each stage.
- Discuss the appropriate interventions and expected outcomes during each of the 5 stages.
- Identify the role of safety devices, switchboard, security, and support staff.

# Learning Objectives



- Identify team member's role to the extent that the tasks/functions of the Intervention Leader, Code Manager and Support Staff are listed during small group discussion.
- Discuss the importance of debriefing and review from an individual, team and system perspective.

# Stages of a Violent Episode



Triggering

Escalation

Crisis

Recovery



# The Triggering Phase

- All people have a normal/baseline set of behaviors. Almost everyone's normal behavior is non-aggressive for most of the time.
- **The triggering phase is the person's first behavior that indicates a movement away from how they usually behave.**

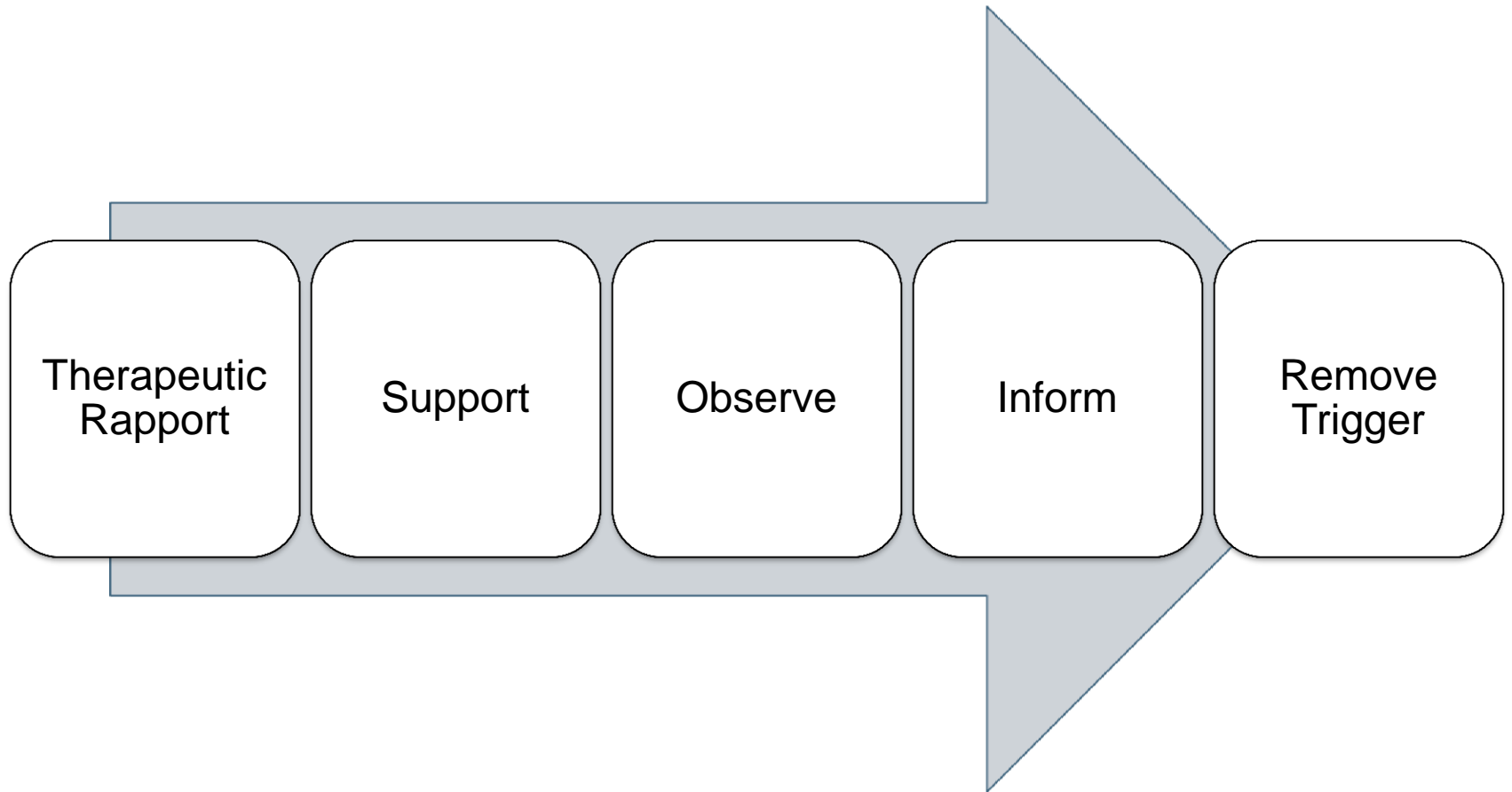
# The Triggering Phase



- The change in behavior may reflect a sense of feeling psychologically ill at ease.
- The early warning signs may be missed if you do not have a detailed understanding of the person.

# Triggering Phase

- Interventions





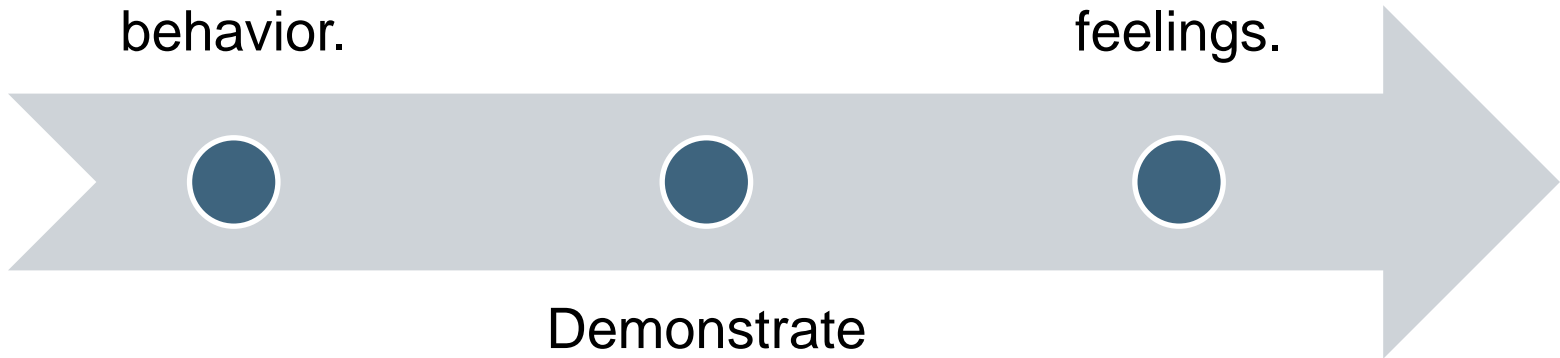
# Triggering Phase



- **Goals/Outcomes**

Abort or rapidly  
diffuse  
impending  
violent  
behavior.

Verbalize  
feelings.



Demonstrate  
alternative  
ways of dealing  
with aggressive  
feelings.

# The Escalation Phase



The client deviates more and more from his/her baseline behavior and it becomes difficult to divert the client to more appropriate activities.

**The client becomes overly focused on a particular issue and less likely to respond to any form of rational intervention.**

This phase leads to assault behavior.

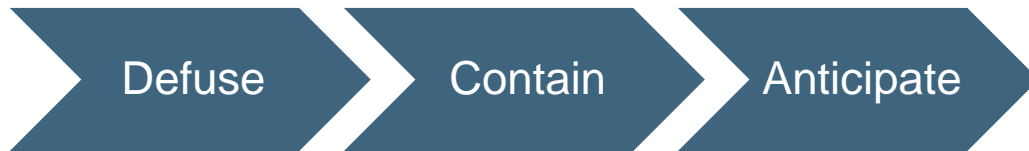


# The Escalation Phase

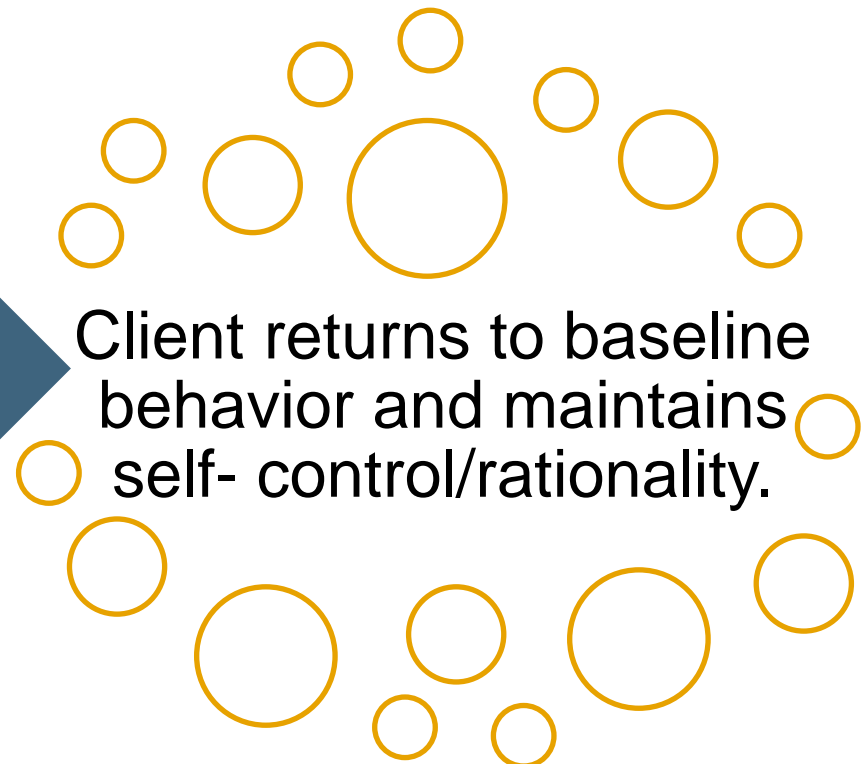


## Interventions in Phase B

## Goals/Outcomes in Phase B



Client returns to baseline behavior and maintains self-control/rationality.



# The Crisis Phase



This phase is characterized by a loss of rationality with increasing physical and emotional arousal.

Assault is likely as control over aggressive impulses lessens.



# The Crisis Phase

## Interventions



- Activate the Panic Alarm
- Press and hold the button for at least 3 seconds
- Longer is better



# The Crisis Phase Interventions



**Call 55555**

**“Code White”**

**Campus**

**Building**

**Floor**

**Room Number**

**Area/Department**

**Weapon?**



# The Crisis Phase

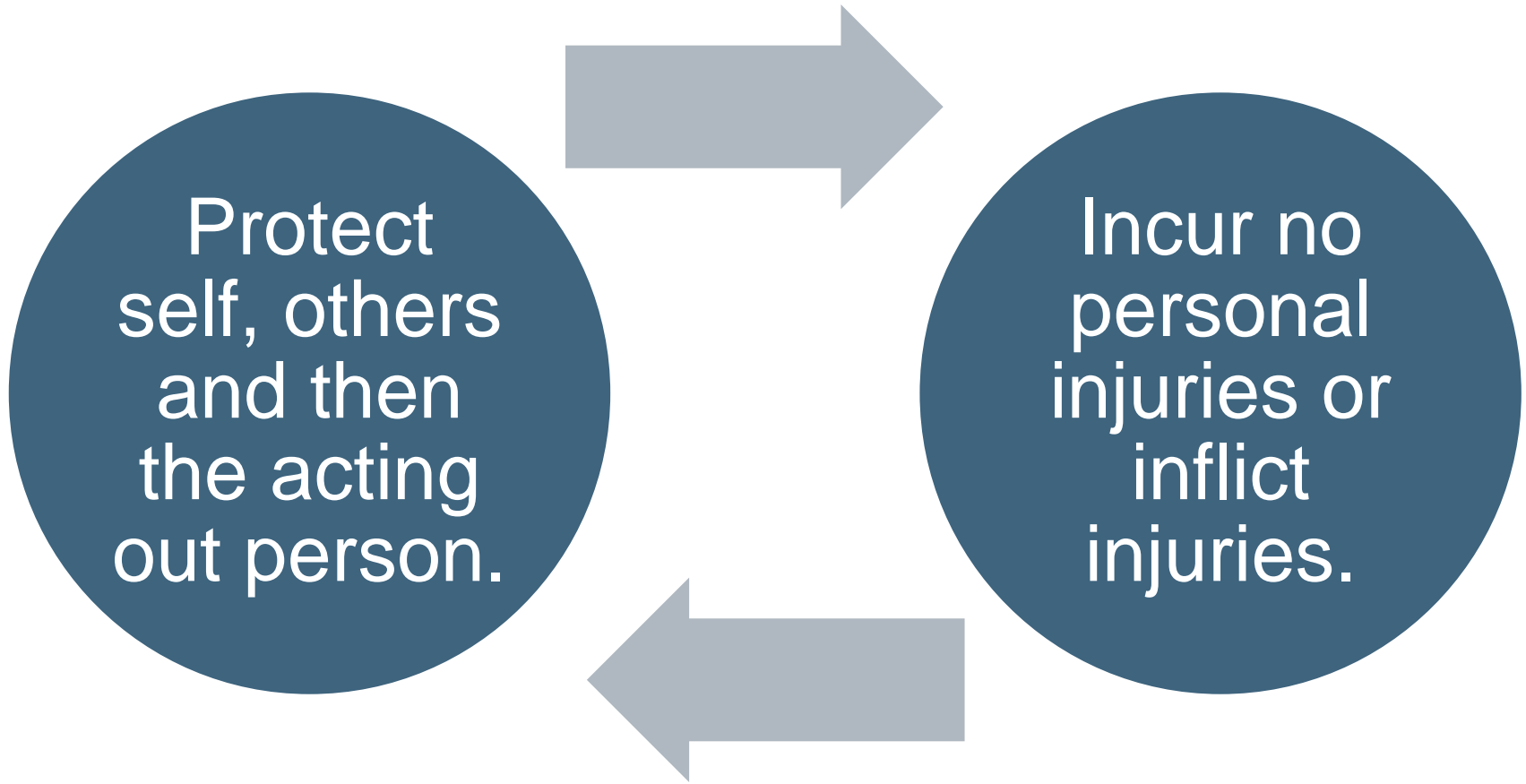


## Interventions

- Recognize your own physical and psychological response to the situation that may impede your ability to act effectively.
- Options may be limited to escape so maintain space of the violent using physical objects to between yourself and the violent person.
- Engage in a planned, approved physical restraint technique(s) only if adequate help is available (unit staff, hospital staff, security).

# The Crisis Phase

## Goals/Outcomes





# The Recovery Phase

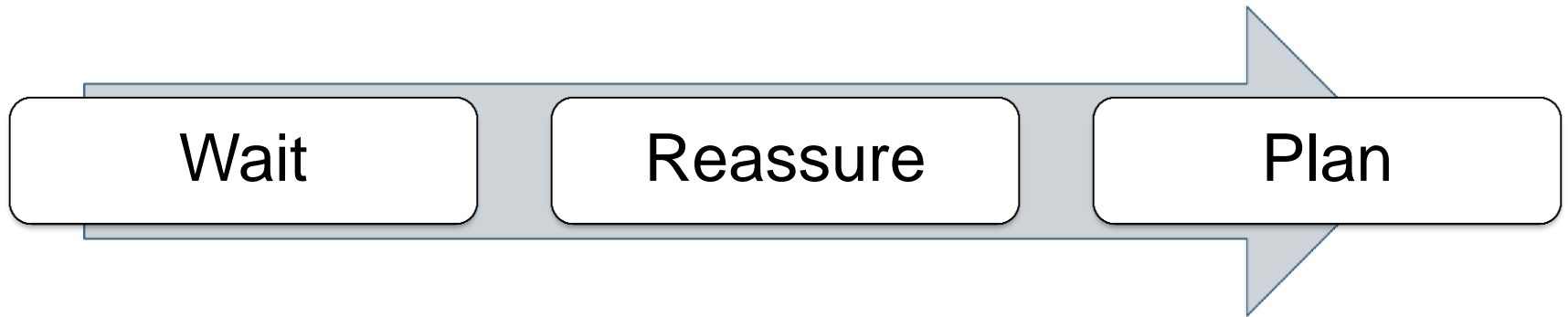


- The client (and you) will gradually return to normal baseline behavior.
- **Due to the high state of physical and psychological arousal, the client can remain a threat for one and a half hours after the incident. Once produced, adrenaline levels remain effective for 90 minutes.**
- Inappropriate engagement of the client at this point leads to staff injury. Avoid insisting on a discussion of why he/she had been feeling violent.



# The Recovery Phase

## Interventions



# The Recovery Phase (D)

## Goals/Outcomes



Return to baseline behavior.

Maintain staff, milieu and client safety.



# Post-Crisis Phase

- The client regresses below baseline behavior: Tearful, remorseful, guilty, ashamed, distraught or despairing are behaviors exhibited by the client.
- Mental and physical exhaustion is common.





# Post-Crisis Phase Interventions

Prevention

Support

# Post-Crisis Phase



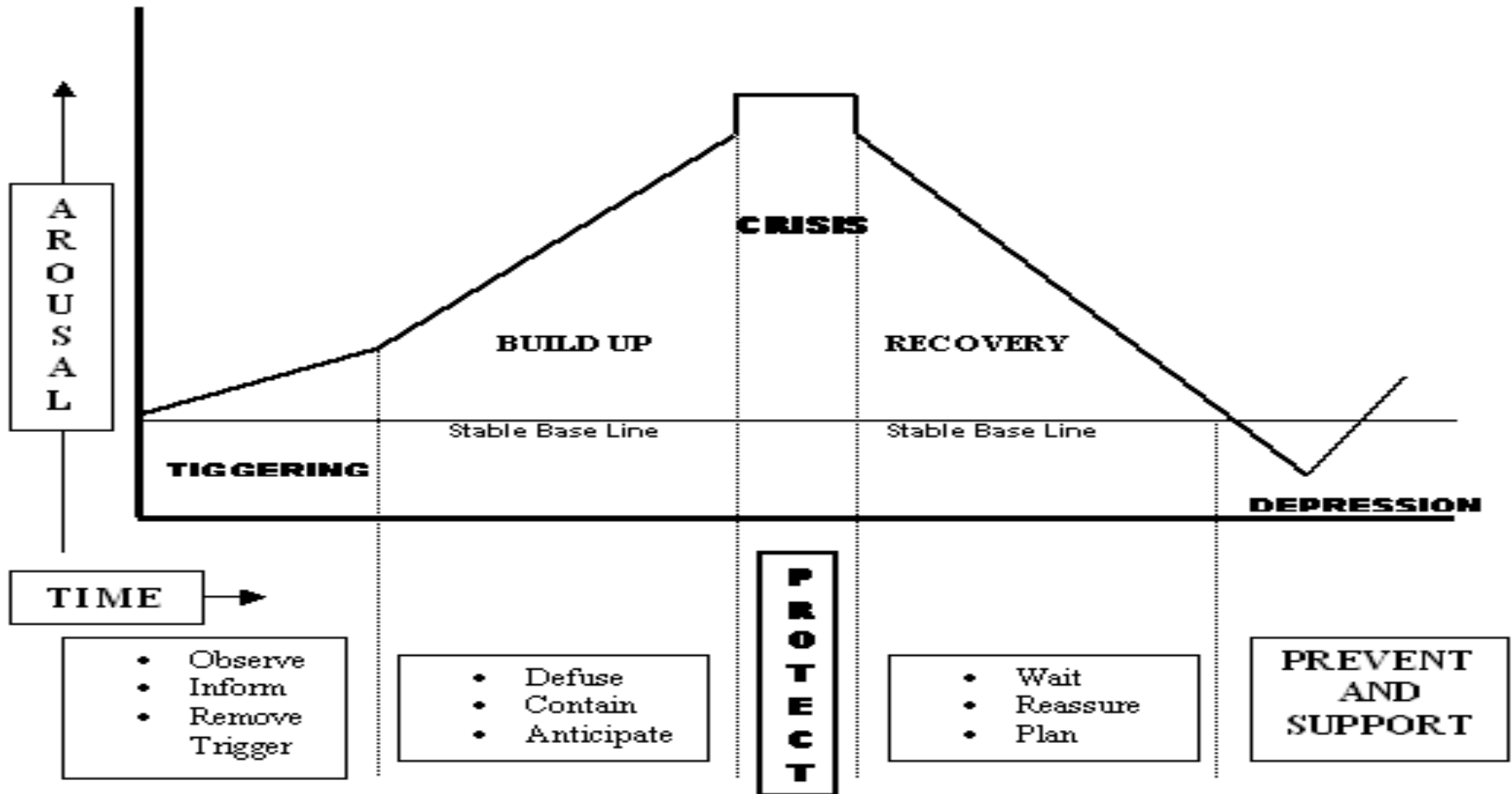
- **Goals/Outcomes**

Gain insight/understanding of the incident and behavior.

Assist the client in learning more effective ways of dealing problematic behavior.

**Clients are often receptive to new learning/interventions aimed at relieving feelings of guilt.**

# Stages of a Violent Episode



**NOTE: PROTECT SELF FIRST, OTHERS SECOND & PERPETRATOR LAST**

# De-escalation Techniques



- Violence does not occur in isolation. It is often in response to aversive stimulation by staff.
- It is important to realize that there are **3** types of aversive stimuli in the patient-staff interaction → triggers

Frustration

Perceived  
Attacks

Activity  
Demand



# De-escalation Techniques



## Frustration

Staff are frequently called upon to set limits on patients as part of the overall plan of care. For example, preventing a detained suicidal patient from leaving the unit.

# De-escalation Techniques



## Perceived Attacks

Aggressive behavior is often in response to a perceived attack. For example, the nurse gives an injection that causes pain; touches a patient who is experiencing a disturbance in personal boundaries.

# De-escalation Techniques



## Activity Demand

Violence may sometimes be in response to instructions from staff to engage in some activity. For example, the nurse demands that the patient get out of bed. Patients may feel insulted, criticized or threatened by staff

# When are de-escalation techniques used?



- De-escalation techniques are to be used to decrease a patient's level of arousal in order to engage in effective problem solving and avoid the risks associated with a violent encounter.
- It is appropriate to engage in de-escalation techniques in the **Triggering Phase** and the **Escalation Phase** of a potentially violent episode. It is important to realize that as the arousal increases, rationality is diminished. As a result de-escalation techniques may be inappropriate; clinical judgment is needed.



# Techniques/Strategies

Allow the person space & time

- Invite the patient to ventilate and express their feelings.

“Please tell me what is upsetting you”

“I have plenty of time ... take your time and tell me what is upsetting you”

“Let’s sit down and you can tell me the problem”

# Techniques/Strategies



## Show concern and understanding

- This is accomplished through reflecting back to the patient that we are listening and comprehending the patient's predicament.

“I want to make sure that I have understood this properly”

“I can see you are quite upset”



# Techniques/Strategies

## Make a token concession

- If a person makes a concession in a tense situation, it “defuses” the interaction. This is referred to as the 1% technical error strategy. It is a minor concession to break a deadlock and “save face” without giving in to unreasonable demands or apportioning blame.

“I can understand your point”

“Well this is a large organization and things can go astray”



# Techniques/Strategies

Make a friendly gesture

- Meeting antagonism with a friendly gesture promotes gratitude.

“Come into my office and we’ll talk”

“I can give you some information that might help”

“Would you like me to phone the office for you?”





# Techniques/Strategies

Convey a desire to reduce distress and acknowledge partnership

- Having acknowledged the patient's feelings, the next step is to indicate a desire to help and a positive orientation to resolving the problem.

“I am positive we can work something out”

“Let me assure you that I will do my best to find out what's happened”

# Techniques/Strategies



## Depersonalize the issues

- This technique is most used when one has to refuse a patient's request. It may be prudent to deflect the onus of responsibility to a greater or unseen authority.

“Our hospital doesn't allow people to smoke in their rooms so we will have to find another solution”

“Fire regulations tell us we cannot block doorways so we will have to ask your mom to take your cello home”

# Techniques/Strategies



## Personalize yourself

- Most commonly used when one is receiving abuse because of one's job or role. Giving some minor information about one's self serves to remind the aggressor that one is a person and not "just a nurse".

"I would be really worried about leaving my cat alone too. She hates that."

"It's hard to feel so alone. When I went away to university I had no family there."

# Techniques/Strategies



## Empower the patient

- Within the context of a helping relationship there is an imbalance of power. Enabling the patient to make choices reduces resentment or antagonism.

“If I came to you with the same problem, what advice would you give me that you feel would be acceptable”

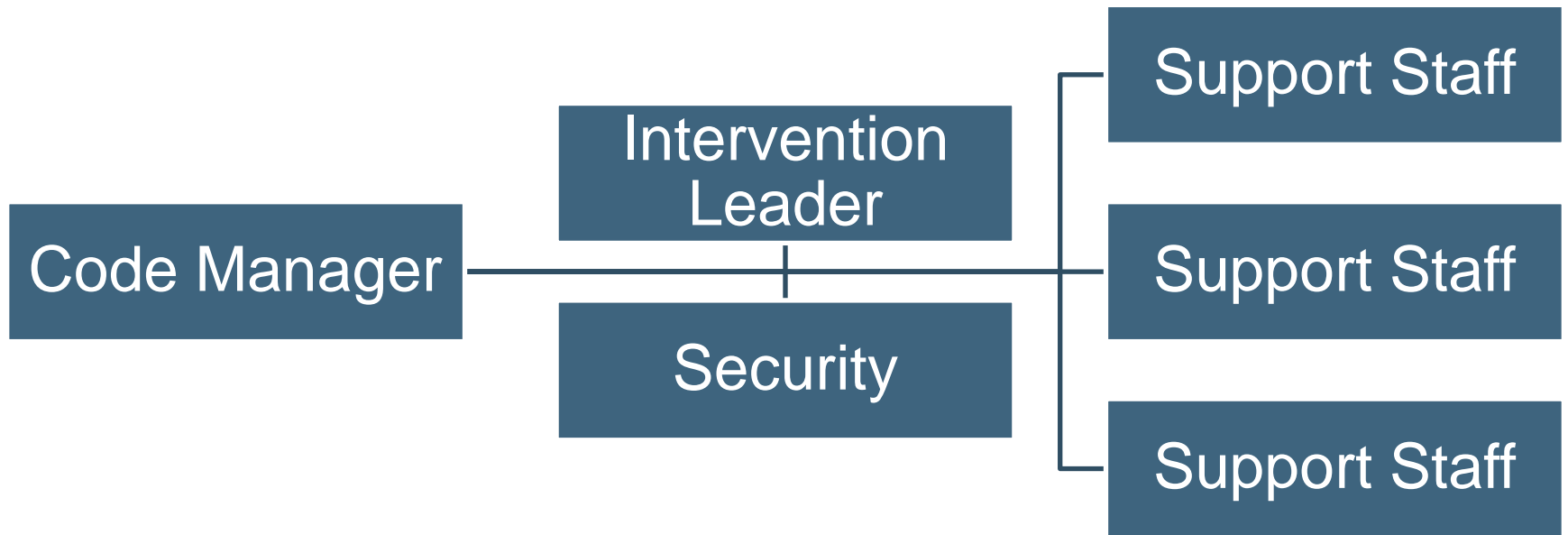
“You have managed to sort bigger problems out in the past and I am sure you will sort this out. However, if you need me, I am here to help”



## Learning Point

**Take a few minutes to reflect on a time when a patient required de-escalation. Using your own words and techniques outlined above, write down a few helpful phrases to defuse a potentially violent encounter.**

# Team Members' Roles



# Code Manager

Think  
Environment & Everything else



- Call for help: Initiate Code White by dialing 55555 or activating a personal panic alarm.
- Note time of incident and interventions.
- Give report to Security of pertinent patient history leading to acting out/violence.
- Delegate activities to appropriate team and support staff.
- Notify the Attending Psychiatrist that the patient's status has changed.
- Safety of the room

Think  
Environment & Everything else

# Code Manager

pg. 2



- Obtain/ready medication
- Arrange for physical restraints to be placed on patient's bed as directed by leader.
- Redirect co-patients and additional staff.
- Initiate incident report.
- Facilitate debriefing.
- Check for any injuries of staff or bystanders



# Intervention Leader

Think  
Dealing with the Patient



- Attempts de-escalation by allowing the person time and space, showing concern, understanding, making a token concession, making a friendly gesture, conveying a desire to reduce the patient's distress, depersonalizing the issue, personalizing yourself, empowering the patient, acknowledging a partnership in problem solving the situation together.
- Provides clear, simple behavioral directives
- Communicates with the patient the plan to help him/her to regain control and/or maintain safety.

# Intervention Leader

Think  
Dealing with the Patient

pg. 2



- Makes the decision regarding the most appropriate level of intervention based on knowing the patient and following the principle of least intrusive intervention. For example: time out, support, medication, and restraint.
- Monitors patient during physical restraint and monitors vital signs.
- Communicates clear directions to the team.
- Ensures that the team members' restraint holds are appropriate.

# Support Staff



- Keep your eyes on the intervention leader or the patient.
- Will take direction from the intervention leader when dealing directly with the patient i.e. Physically holding patient.
- Carry out tasks delegated by the Code Manager when not directly involved with the patient.
- Refrain from talking unnecessarily
- Refrain from interacting with the patient unless explicitly directed to do so from the Intervention Leader.

# Security



- Receives notification through Switchboard via portable page of Code White.
- Liaise with Code Manager to bring about safe resolution of Code White.
- Can safely apply physical restraints as directed by Intervention Leader.
- Will request London Police assistance as needed.

# Debriefing



- There is an informal debriefing with the team and staff involved in the incident immediately following the incident.
- This provides the opportunity to complete documentation and for each team member to make comments, voice concerns & issues.

# Debriefing



- This is a time to discuss what went right, what didn't and to make recommendations on how to improve the Code White Response.
- If there have been injuries, further documentation will be required and a more involved debriefing will be available.



# References

- [LHSC Code White Policy](#)
- LHSC Mental Health Intranet