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CLAIMS Rx

RISK MANAGEMENT PERSPECTIVES

Disruptive Patient Behavior:

Mitigation and Management Strategies

ProAssurance

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RISK MANAGEMENT PERSPECTIVES

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Disruptive Patient Behavior:
Mitigation and Management Strategies

INTRODUCTION

"Disruptive patient behavior, particularly violence, is a growing problem that has been exacerbated by the COVID-19 pandemic."[1,2] Although conflicts over COVID vaccines, treatments, and masking may have waned, a legacy of distrust and disruptive behavior remain.

Disruptive behavior can be defined broadly as patient behavior that has or could jeopardize 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 behavior poses an obvious risk to clinician and staff well-being. But disruptive patients also can undermine their own health by impacting the medical decision-making process, and may be more likely to pursue malpractice lawsuits.[4]

By identifying and understanding patterns and triggers of disruptive behavior, clinicians and staff can reduce the risks of disruptive behavior and help disruptive patients achieve behavior that allows for collaborative treatment.

Even mildly disruptive patient behavior can interfere with clinical decision-making,[5] which can result in diagnostic error. Research indicates that emotional reactions to disruptive behavior can deplete a clinician's cognitive resources.[6,7] Further complicating matters, clinicians are often unaware of the effects of emotion on diagnostic reasoning.[8] This can make it difficult to mitigate the effects that disruptive behavior may have on patient safety. During disruptive patient encounters, obtaining assistance from a person with expertise in managing patient behavior (e.g., a social worker), can allow clinicians to better focus on the patient's medical issues.

Different kinds of disruptive patient behaviors require different de-escalation and continuity of care strategies. For example, a patient who is verbally abusive because of a perceived service failure might be successfully calmed to a degree that the basis for their anger can be discovered and remedied. In that case, the appropriate next step might be a behavior warning or a patient behavior agreement. On the other hand, 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 would be appropriate. Managing a situation involving a disruptive patient often requires balancing patient rights against the well-being of the healthcare team. Sometimes, disruptive patient behaviors destroy the therapeutic relationship. In that case, termination of treatment with proper notice may be appropriate.

By identifying and understanding patterns and triggers of disruptive behavior, clinicians and staff can reduce the risks of disruptive behavior and help disruptive patients achieve behavior that allows for collaborative treatment. Policies, protocols, and staff and clinician training on how to effectively mitigate and manage disruptive behavior is a crucial aspect of ensuring staff and patient safety and well-being.[9]

The case studies in this month's publication are based on closed claims and Risk Management department calls from insureds. These scenarios 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 on 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.

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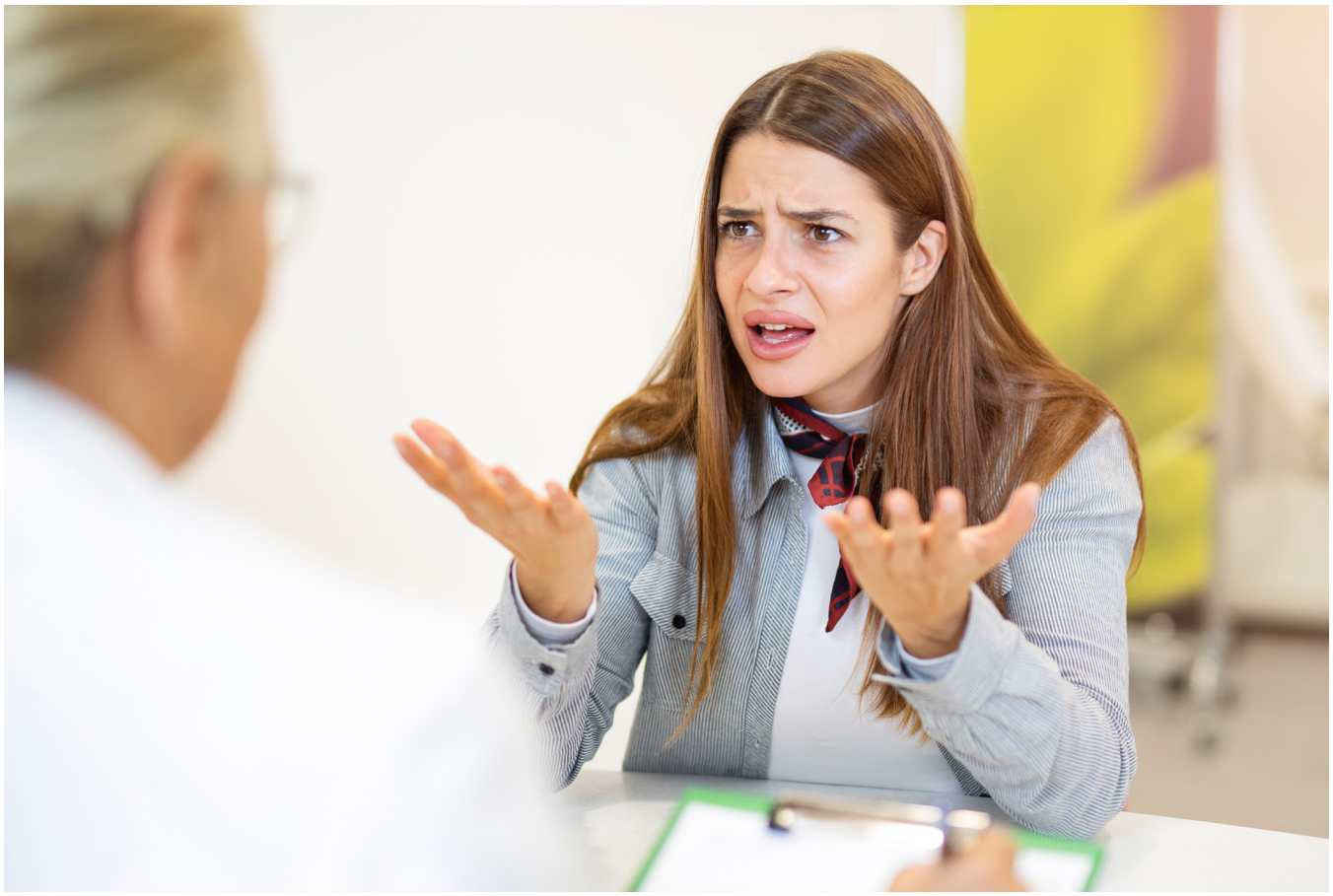

Failure to Document Disruptive Behavior

When a malpractice lawsuit is filed, lack of documentation can significantly complicate the process of proving the patient's treatment met the standard of care and did not cause the patient's injury. In the following case, the emergency department (ED) physician failed to adequately document three different aspects of the patient's care: her disruptive behavior, her departure from the ED against medical advice (AMA), and her follow-up telephone conversation. Each failure complicated the defense of the ED physician's case.

CASE ONE:

Allegation: Delayed diagnosis and treatment of the patient's infection caused permanent heart damage.

Late on a Friday afternoon, a patient called her primary care physician (PCP). She requested a refill of oxycodone for what she believed was a flare up of her sciatica. She reported it was interfering with her sleep and she felt tired and "jittery." Because the physician was not convinced the patient's symptoms were entirely attributable to sciatica-induced sleep loss, due to some mild irregularities in blood test results from a recent visit, and his office was about to close for the weekend, he refused the patient's request for a refill and told her to go to the ED.

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The patient's loud, profane complaints started in the ED waiting room. Therefore, she was placed in a private examination room. She demanded to see a physician and obtain a prescription for oxycodone, consistently ordering staff out of the room shortly after they entered. When the ED physician examined the patient and attempted to obtain a history, she dismissed the necessity and demanded a prescription for oxycodone. Based on the history, exam, and recent blood test results forwarded from the PCP's office, renal insufficiency, dehydration, heart failure, and infection were in the ED physician's differential, in addition to sciatica. He ordered various tests, including blood cultures, and some non-narcotic pain medication for the sciatica. Ten minutes after the ED physician left the room, he was called back because the patient was threatening to leave.

After additional conversation with the patient, the ED physician believed he had established agreement on his plan of care: The patient would stay in the ED until the test results came back, and they would make treatment plans based on the results. Thereafter, he was called back to the room multiple times as the patient refused lab draws, diagnostic studies, and treatments the ED physician had recommended. The patient also left the room to find the ED physician, presenting at the bedsides of other patients, all the while continuing her tirade and demanding a prescription for oxycodone. Despite the difficulties, nurses were ultimately able to obtain blood samples.

While this was going on, the ED physician was also trying to deal with an electronic health record (EHR) system that was not working properly. His ability to enter orders for blood tests, resuscitative measures, hospitalist consultations, and progress notes into the patient record was affected. The EHR problems resulted in significant delays in the patient's treatment. Later, the ED physician created progress notes from the various pieces of scratch paper he had relied on. However, he failed to mention the patient's disruptive behavior, treatment refusal, or threats to leave the ED if she was not provided with a prescription for pain medications.

After three hours in the ED, the patient left AMA, explaining she had come to the ED for an oxycodone prescription, "not a bunch of tests." The next day, the laboratory reported positive blood cultures to the ED physician, who called the patient's home. The patient's husband answered the telephone and informed the physician that his wife refused to speak with him. The ED physician reported the positive results and told him to bring the patient to the hospital for treatment. The husband informed him that the patient had a follow-up appointment with her PCP the next day, and she would discuss the matter with the PCP. The ED physician did not document anything about this call.

Although the patient was seen by the PCP as planned, the PCP had not received the blood culture results or any other information from the ED visit. The patient complained bitterly about her ED visit but provided no clinical information. She did not inform him of the ED physician's phone call. Since the patient's sciatica continued to bother her, she denied any other symptoms, and since oxycodone had been effective for the patient in the past, the PCP prescribed it and physical therapy. Three months later, the patient was diagnosed with endocarditis. It was caused by the same bacteria identified during the earlier ED visit. The patient sued all members of her healthcare team for delayed diagnosis and treatment of the infection, which caused permanent heart damage.

DISCUSSION

This patient's treatment was complicated by multiple issues—her disruptive behavior was only one of them. However, it is possible that more effective management of her behavior may have circumvented her departing the ED, and instead resulted in hospitalization, where her infection most likely would have been treated. The defense of the case was complicated by the ED physician's failure to document any aspect of the patient's disruptive behavior, other than the fact that she left AMA. In deposition, the patient was entirely pleasant and cooperative, and denied disruptive behavior. She testified that she had left the ED due to her extreme discomfort, which was exacerbated by the chaos in the ED. Believing her only problem

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was sciatica, which had been bothering her on and off for years, she made the decision to "tough it out" until her appointment with her PCP. Based on past sciatica flare-ups, she assumed her PCP would give her the prescription for oxycodone; she would take the oxycodone for a week or so during the worst of the pain; and once the pain subsided, she would stop taking it. She and her husband denied being told about the infection and denied getting a call from the ED physician. The hospital landline to patient landline call history record for the date in question was no longer available, so there was no evidence other than the ED physician's testimony of the call being made.

Without the documentation of disruptive behavior, the defense team worried that a jury could question the ED physician's recollection of the difficulties he had obtaining the patient's cooperation with treatment recommendations. They also believed that the only way the defendants could put forth a united defense at trial would be if the ED physician's recollection of the events were believed. The jury would also have to be convinced of some basis for the patient and her husband ignoring the ED physician's recommendation to return to the hospital for treatment and failing to inform the PCP of the infection information relayed to them by the ED physician. Although this might have been the truth of the matter, it would be difficult to argue without documentary evidence.

RISK REDUCTION STRATEGIES

Because of the time that passes between encounters with patients and litigation, clinicians will most likely not remember relevant facts or will remember facts that are not consistent with patient memories and/or memories of other members of the healthcare team. If there is no documentation regarding the patient's behavior, advice given, risks discussed, content of telephone calls, etc., the patient's or a loved one's testimony about the content of discussions or patient behavior cannot be verifiably disputed.

In addition to supporting the defense in malpractice litigation, adequate documentation of disruptive behaviors promotes healthcare team safety and well-being during future encounters with the patient (a topic that will be discussed later in this article), by serving as a warning and prompting mitigation measures. Consider the following documentation strategies:

DISRUPTIVE BEHAVIOR STRATEGIES

- Objectively record the details of disruptive patient encounters in the patient's record, including your response to the behavior.
  - ► Do not record subjective, judgmental, or derogatory comments about the patient or family members.
  - ► Do not include or refer to incident reports.
- Create a disruptive behavior flag in the EHR, or request that one be created. (See "EHR Disruptive Patient Flags" content below.)

LEAVING AMA STRATEGIES

- Objectively record the details of the encounter resulting in the patient leaving AMA, including:
  - ► An assessment of the patient's decision-making capacity, including statements attesting to the patient's ability to understand the risks and benefits, that the patient was given an opportunity to ask questions, and that he or she was encouraged to return.
  - ► The patient's given reasons for leaving.
  - ► Communicated benefits of remaining to obtain proposed treatment/observation, alternatives to proposed treatment and leaving AMA, and the risks of leaving AMA that were discussed with the patient.
  - ► Your efforts to keep the patient from leaving AMA (e.g., the number of times you returned to reiterate the risks, benefits, alternatives; engagement of loved ones; strategizing with social workers).

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RISK REDUCTION STRATEGIES continued

- Follow-up instructions (i.e., specific follow-up needed and directions for the patient to follow up with a named clinician on a specific date) and any pending test results.
- Instructions to the patient about what symptoms to look for and what to do should his or her condition worsen.

- Have the patient sign an AMA form (to support the process, but not replace it) in front of a witness. Scan the form into the medical record and provide the patient with a copy of the signed form.
  - If the patient refuses to sign the form, document the refusal.
- Identify any person who accompanied the patient at departure, and record additional information provided directly to that person.

TELEPHONE FOLLOW-UP STRATEGIES

- Document telephone encounters with the same level of importance as documentation of in-person visits.
- Include the following information when documenting a patient telephone follow-up encounter:
  - Patient's name.
  - Call recipient's name if different than the patient (e.g., spouse or child with authority to discuss the patient's medical information).
  - Return phone number.
  - Date and time of call.
  - The prompt for the follow-up.
  - Advice or information given to the patient, including:
    - Requests for the patient to come into the office, go to urgent care centers or hospital emergency departments, call back if there is no improvement in their condition or if they have additional symptoms, etc.
  - Patient responses to information or recommendations, including refusals.
    - Possible consequences of failure to follow recommendations discussed with the patient.
  - Disposition of the call.
  - Signature and name of the clinician making the call.

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. Understanding what causes disruptive behavior can help prevent and de-escalate it.[10]

INTERPERSONAL TRIGGERS

Disruptive behaviors can be triggered by what you say, how you say it, and how you behave, which can be colored by the patient's perceptions, for example: [11,12,13]

What you say

- Giving the patient "bad news."
- Demanding compliance/failing to offer the patient choices.
- Reprimanding the patient.

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RISK REDUCTION STRATEGIES continued

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.
- Limiting or prohibiting visitors.
- Making a patient wait.
- Failing to follow through with promises.
- Discharging a patient who wants to stay or holding a patient who wants to leave.

How you behave

- 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.
- 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:[11,12,13]

- 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, the patient's birthday or holiday) or a triggering time of day (for example, more violent events occur in the evening in the emergency department).

SYMPTOMS OF THE PATIENT'S ILLNESS

Disruptive behaviors may be caused by the patient's current illness or underlying medical condition, for example:[11,12,13]

- 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.
- The patient is suffering from a nervous system disorder (e.g., hepatic encephalopathy).

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RISK REDUCTION STRATEGIES continued

NONVERBAL CUES OF IMMINENT INTERPERSONAL VIOLENCE

Knowing when a patient is likely to become violent is ideal, but difficult. Patients may signal they are getting ready to lash out against their healthcare team members through nonverbal communication, including:[14,15,16]

Body Movements

- Pacing, gesturing in an exaggerated or violent manner, assuming a boxer's stance, removing excess clothing, opening and closing 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 themself.

Eye Contact

- Glaring or avoiding eye contact.

Physiological Changes

- Flushing, pallor, sweating, extreme fatigue, rapid breathing, pupil dilation.

Of course, all 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. There are multiple risk assessment tools to help in the early identification of aggressive behavior, which can be paired with early de-escalation intervention. The STAMP (Staring, Tone and volume of voice, Anxiety, Mumbling, and Pacing) Tool[17] and the Brøset Violence Checklist© (BVC)[18] have been shown to be effective, and have been validated for reliability in different settings.[19]

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Failure to Use De-escalation Strategies

In the following case, the patient and his wife were removed from the ED for using profanity and issuing threats. The patient may not have become disruptive if de-escalation strategies had been used. Consider what could have been done differently.

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

CASE TWO:

Allegation: Delayed diagnosis of epidural abscess resulted in paraplegia.

On a Monday, a man presented to the ED with severe lower back pain. After an unsuccessful trial of oxycodone, he was given IV pain medications, which brought his pain down to a manageable level. He was discharged with a diagnosis of muscle strain, given a prescription for oxycodone and muscle relaxants, and instructed to follow up with his PCP.

On Tuesday morning, the patient returned to the ED via ambulance. He reported 10/10 back pain with no relief from the medications prescribed the day before. A different ED physician ordered an MRI, but the patient was unable to lie still because of the pain. He was returned to the waiting room. The ED physician ordered oral oxycodone, with the plan to try oxycodone first, then try stronger pain medications if the oxycodone did not achieve the pain relief necessary to allow the MRI to go forward. A nurse brought the patient oxycodone, explaining it would relieve his pain and allow him to lie flat for an MRI. Very loudly and profanely, the patient

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informed the nurse that he had tried oxycodone, and it didn't work. He demanded immediate administration of the same intravenous pain medications he had been given the previous day. The nurse informed the patient that she could not administer what the physician did not order. She gave the patient and his wife a warning about their behavior, telling them they would be removed from the premises if they did not calm down. In response, the patient's disruptive behavior escalated. Between bouts of swearing and moaning in pain, he demanded to see a physician, refused to leave without getting an MRI, and threatened to hire a lawyer. His wife loudly made vague threats about hurting people if her husband didn't get the pain relief he needed. The security guard, at this point, determined the patient and his wife met the criteria for being removed from the premises. He wheeled the patient 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. He sued every person on his healthcare team.

The nurse gave the patient and his wife a warning about their behavior, telling them they would be removed from the premises if they did not calm down. In response, the patient's disruptive behavior escalated.

DISCUSSION

Viewed in retrospect, the cause of the patient's mounting frustration, agitation, and anger is understandable: he was in significant pain; and he had achieved relief the previous day with IV medications, but he continued to be offered oxycodone, which was not working. While threats of harm and 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 his demands for intravenous pain medication and removing him from the ED.

The ED physician also should have reviewed the patient's recent history, discussed her pain management strategy with the patient, and considered an alternative to oxycodone, based on the circumstances. 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 he undergone surgery earlier.

RISK REDUCTION STRATEGIES

Violent individuals do not "just snap."[9] Disruptive patient behavior can be avoided, mitigated, and appropriately managed. It requires strong disruptive patient and workplace violence policies and procedures with flexibility to allow clinicians and staff to individualize the response depending on the potential of danger. Individualizing a response requires appropriate training; therefore, it is important to provide the necessary tools to clinicians and staff to protect their safety while also satisfying patient healthcare needs.

CLINICIANS AND STAFF

Consider the following strategies:[20,21,23,24]

- Mitigate personal safety risks when interacting with a patient (or patient's family member) who has a history of violence, including:
  - Determine the best plan for potentially violent patients on the schedule for the day during the daily huddle or during a huddle specifically devoted to the particular patient.
  - Share information about a patient's potential for disruptive behavior with members of the healthcare team who do not have access to EHR warnings or huddles.
  - Request an additional staff member to be present during encounters.

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RISK REDUCTION STRATEGIES continued

- Involve a social worker, who can help de-escalate, so the clinician can focus on the patient's medical issues.
- Remove potential weapons from the examination room (e.g., lamps, fire extinguishers, etc.).
- Search the patient for items that may be used as a weapon.
  - Inventory and secure personal property that could be used as a weapon (e.g., an insured was attacked with a bicycle seat).
- Treat known aggressors in relatively open, easily accessible areas that still reasonably maintain privacy (e.g., rooms with removable partitions).
- If an easily accessible area is not available, position yourself between the patient and the door.
- Maintain two arms' length of space between you and the patient.
- Reinforce behavioral expectations with the patient.

- Avoid triggering disruptive behavior, particularly when the patient is exhibiting signs of imminent violence. (See "Triggers of Disruptive Behavior" and "Nonverbal Cues of Imminent Interpersonal Violence" content above.)
- Maintain your composure if a patient becomes disruptive.
  - 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 then take a break. Have a plan before you resume the encounter.
  - Use "I" messaging to communicate how you feel, why you feel that way, and how the individual 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."
- Discover what has triggered a patient's disruptive behavior and how the individual wants the situation resolved.
  - Focus on what is causing the undesirable behavior, not the behavior itself.
    - 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 can facilitate your understanding of the individual's feelings and intentions, for example, ask: "What is your major concern right now?" "How can I help?" "What can I do?"
  - Effectively use silence, which can encourage the patient to provide more information and can allow the individual to calm down.
  - Use short, concise sentences, and simple vocabulary. Complex sentences can increase agitation.
- Use active listening techniques, for example:
  - Paraphrase and summarize, using the individual's own terminology, to ensure you understand what the individual is trying to communicate and to show you are listening.
  - Repeat back the individual'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."
  - Avoid telling the patient that you understand if there is no way you would understand.
- Suspend judgment of the individual's behavior.
  - Avoid questions that begin with "why," which can be perceived as judgmental.
  - Put yourself in the patient's shoes to gain perspective on the patient's behavior.

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RISK REDUCTION STRATEGIES continued

- Do not attempt to control behavior that does not impact safety.
- Use body language that can reduce feelings of confrontation (e.g., maintain an open posture and stand at an angle to the individual).
- Find aspects of the individual's position with which you can agree.
- Express optimism by using positive language and avoiding words like "but," "can't," and "don't."
- Offer options for reducing agitation (e.g., "We can give you some medication to help you to feel more relaxed." "Would you be more comfortable in an examination room?" "Can we start this conversation over? I feel like we got off on the wrong foot.")
  - Reach an agreement with the patient about how the situation can be resolved, then follow through.
- If de-escalation strategies are not effective and the patient is threatening your safety, excuse yourself, leave the room or move away from the patient, and then get help.
  - Do not notify the individual that you are calling in help, as this may further escalate his or her agitation.
  - When appropriate, evacuate other individuals who are endangered.
- After de-escalation, if the patient does not pose a safety risk, use rehabilitation strategies to direct the individual's behavior in the future.
  - Explain behavioral expectations and issue behavioral warnings. (A link to a sample behavior warning letter follows Case Four.)
    - 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 Four.)
    - Start the termination process if the patient refuses to engage in behavior modification.
- At hand-off, pass on information about incidents of disruptive behavior or potential safety risks posed by the patient.
- Document disruptive behavior and behavioral expectations for the future.
- Create (or request the creation of) an EHR disruptive patient flag (see content below on EHR disruptive patient flags).
- Report the incident using a process that protects the report from discovery in litigation to the greatest extent possible.
- Seek assistance for personal trauma associated with a disruptive patient encounter.
- Practice de-escalation with colleagues.

OPERATIONS

Consider the following strategies:[20,21,23,24]

- Put workforce violence/disruptive patient behavior policies and procedures in place.
- Ensure patient behavior precautions and interventions can be entered into the EHR in a manner that will alert clinicians and staff to the potential necessity of activating disruptive/violent patient strategies (see content below on EHR disruptive patient flags).
- Train clinicians and staff to mitigate and respond to disruptive patient behavior, including the management of their own stress and frustration that may arise during the encounter.
- Create behavioral response teams.

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RISK REDUCTION STRATEGIES continued

- Put systems in place that facilitate workplace violence reporting by victims and bystanders.
  - Create an environment in which victims do not fear reprisal for reporting violence.
  - Review each incident of workplace violence.
  - Debrief with involved individuals following an incident.
  - Involve victims in the creation of safety risk reduction strategies based on lessons learned from the victim's experience.
- Report incidents to leadership, security, law enforcement, and state authorities as necessary, pursuant to workplace violence regulations and guidelines.
- Provide accessible, effective support for all clinicians and staff experiencing workplace violence.
- Make the workplace safer.
  - "Nudge" (short, personalized recommendations with a clear call-to-action) patient behavior in a positive direction. For example, one health system uses signs reminding visitors to: "Please take responsibility for the energy you bring into this space … your behaviors matter. Our patients and caregivers matter. Take a slow, deep breath and make sure your energy is in check before entering."[25]
  - Post emergency contact numbers (e.g., security and/or police) near the reception desk, nurses' station, or other central locations where clinicians and staff congregate.
  - Use standardized emergency codes over the facility intercom to indicate the presence of a violent or combative individual (e.g., code gray).
  - Prohibit clinicians and staff from working alone, particularly at night.
  - As necessary, install security cameras and security alarms, simplify exit routes, install metal detectors and barrier protections, install panic buttons in strategic locations, improve lighting, and control access in and out of facilities.
  - Mitigate the risk of patients using items in your facility as weapons (e.g., 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).
  - Mitigate the risk of areas in your facility providing an opportunity for assault or hostage-taking, such as empty hallways, unlocked storage areas, or separated work areas.
- Conduct risk assessments regularly to evaluate preparedness for workplace violence.

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ADDITIONAL RESOURCES

Occupational Health and Safety Administration (OSHA): Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers[13]
Voluntary guidelines for preventing workplace violence, which include recommendations for developing policies and procedures to eliminate or reduce workplace violence in a range of healthcare and social service settings

The Joint Commission: Workplace Violence Prevention Resources[26]
A collection of The Joint Commission publications on workplace violence, including links to the Workplace Violence Prevention Standards,[1] which took effect January 1, 2022, for accredited hospitals and critical access hospitals, and the Workplace Violence Prevention Compendium of Resources to Support Joint Commission Accredited Hospitals in Implementation of New and Revised Standards,[27] which provides resources that can be used to help accredited organizations meet the new workplace violence requirements

Minnesota Department of Health: Prevention of Violence in Health Care Toolkit[28]
Resources for facilities seeking to establish a violence prevention program or improve their current program, containing sample policies and procedures, articles, and staff and leader education tools

ProAssurance: Violence in Healthcare[29]
Two-minute video introducing strategies to prevent workplace violence

Janet S. Richmond et al.: Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup[21]
Foundations for appropriate training for de-escalation and intervention guidelines, using the "10 domains of de-escalation"

US Veterans Health Administration: Implementing Multidisciplinary Behavioral Threat Assessment and Management Practice in Health Care: Disruptive Behavior Committee (DBC) Guidebook[9]
Guidebook describing primary violence prevention strategies, secondary prevention strategies that respond to violence as it unfolds, and tertiary prevention strategies for managing the aftermath of violence

American Nurses Association: Reporting Incidents of Workplace Violence[30]
A multifaceted strategy to combat workplace violence, including promoting and instilling a culture of zero tolerance toward workplace violence

Agency for Healthcare Research and Quality (AHRQ): Daily Huddle Component Kit[31]
Strategies and rationales for daily huddles involving members of the healthcare team

Electronic Health Record:
Disruptive Patient Flags

Although workplace safety is imperative, bias and discrimination may result from identifying a patient as violent or disruptive in his or her medical record. As an alternative to a general flag on the record, identifying behavior precautions and interventions can avoid bias (e.g., a brief description of the safety risk and description of appropriate actions to ensure safety), while serving the purpose of alerting clinicians and staff to the potential necessity of activating disruptive behavior mitigation measures. Consider the following strategies:[9]

- Enable click-through from the flag to a more detailed account of the basis for the flag and individualized strategies for mitigating and managing disruptive behavior.
  - Put a process in place for creating, approving, reviewing, and updating flags. Some questions to consider in formulating or adjusting a plan include:
    - Behavior management and risk mitigation strategies that have been effective.
    - Events, situations, or conditions that might trigger the patient.
    - Behavioral changes that may indicate escalating or diminishing risk.
    - Significant life or healthcare events.
    - Key individuals who can provide insight into the patient's behavior.
- Provide training to clinicians and staff on how to create and respond to the flags, and how to identify and manage bias towards disruptive patients.

A more in-depth discussion of disruptive patient record flag use can be found in the U.S. Veterans Health Administration's Implementing Multidisciplinary Behavioral Threat Assessment and Management Practice in Health Care: Disruptive Behavior Committee (DBC) Guidebook[9] starting at page 69.

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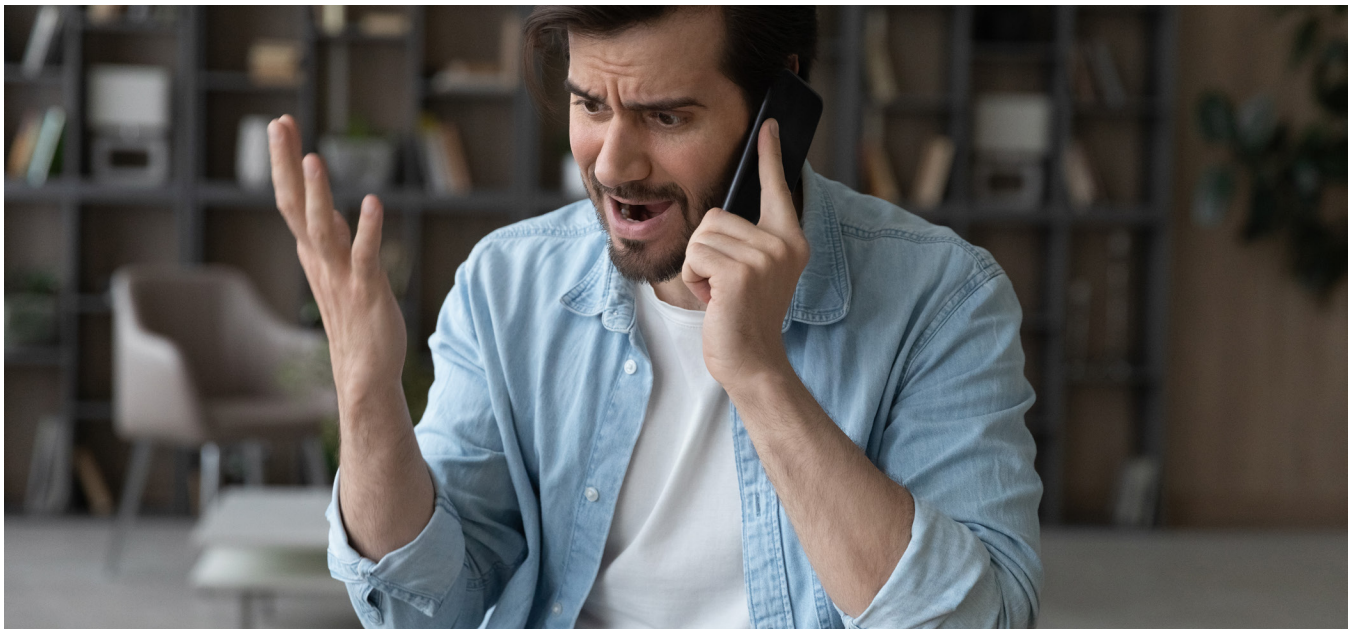

Termination of Treatment Without Notice for Verbal Abuse

Many insureds call the Risk Management department for advice about terminating treatment of a verbally abusive patient who does not pose a safety threat. They worry that dismissing the patient will prompt the patient to file an abandonment lawsuit or will elevate the patient's anger. Although verbal abuse by a patient should not be tolerated and falls within The Joint Commission's definition of "workplace violence,"[1] if it does not include physical threats or violent behavior, it generally will not provide grounds for terminating the treatment of the patient without notice. Terminating treatment without notice following an episode of verbal abuse without an apparent safety risk is more likely to support an abandonment claim. Consequently, the better strategy is to give the patient notice, and continue treatment through the notice period.

However, 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 also help successfully defend the allegation.

The following two cases show opposite sides of the spectrum when it comes to terminating treatment of a disruptive patient. In Case Three, the practice wanted to terminate treatment too quickly. In Case Four, the physician probably waited too long. Risk reduction strategies and resources for disruptive patient rehabilitation and termination of treatment follow Case Four.

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CASE THREE:

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 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.

Issue: Because the patient used abusive language with the receptionist, the practice wanted to terminate treatment without notice.

DISCUSSION

There were a couple of complicating issues in this scenario. Generally, once a physician-patient relationship is established, the physician has an ongoing responsibility to the patient until the 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."[32] 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 appeared minimal. Therefore, terminating treatment of the patient without notice presented a high risk of an abandonment claim. The insured was advised to give the patient adequate notice if she intended to follow through with termination of treatment. Risk reduction strategies for terminating treatment of disruptive patients follow Case Four.

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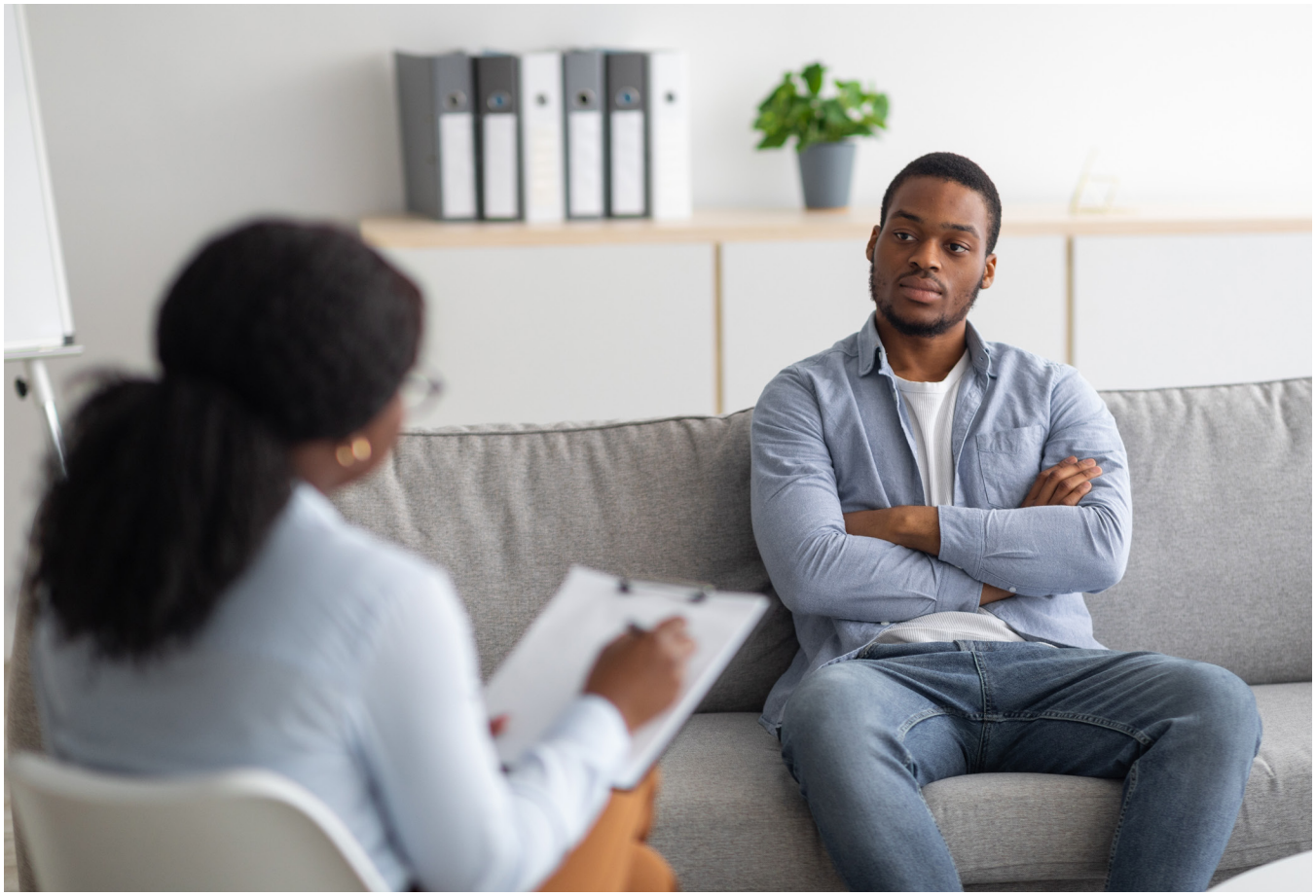

Delayed Termination of Treatment After Sexual Harassment

The handful of studies that have examined the prevalence of sexual harassment by patients suggest it may be significant.[33,34] The American Medical Association ethics code defines sexual harassment as: "Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature."[35] (Of course, this refers to physicians harassing others, but the definition suffices for patient-perpetrated harassment.)

In the following case, a psychiatrist continued treatment of a patient who sexually harassed her. The psychiatrist's persistent unwillingness to enter into a sexual relationship with the patient prompted a series of patient self-terminations from treatment. Because the psychiatrist considered patient harassment a hazard of her job, she consistently reinstated treatment, with admonishments and agreements for acceptable behavior. This went on for the better half of a year. In retrospect, the psychiatrist would admit that she should have terminated treatment at an earlier stage and facilitated referral to a different psychiatrist.

CASE FOUR:

Allegation: The physician negligently caused the patient to act on his sexual attraction to her, then negligently failed to refer him to a different psychiatrist, which resulted in his psychological injuries.

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On December 30, 2018, a 20-year-old male presented as a new patient to a psychiatrist. The psychiatrist recommended treatment two times per week and prescribed medications for depression and anxiety. Early in the third week of treatment, the patient stood, grasped his erect penis through his clothing, and announced his state of sexual arousal caused by the psychiatrist. She admonished him and told him his behavior was unacceptable. The next week, at the end of the session, the patient pulled the psychiatrist into an embrace and explained he was feeling an overwhelming sexual attraction to her. The psychiatrist immediately pulled away, admonished the patient, and obtained agreement from him to refrain from sexual innuendo or physical contact in the future.

However, two weeks later, the patient challenged the psychiatrist to stop him from removing all his clothing and started to undress. In response, the psychiatrist advised she would call building security if the patient followed through on his threat. The patient then threw a vase in the psychiatrist's direction, screamed he never wanted to see her again, and left her office. After this episode, the psychiatrist assumed the patient had terminated the therapeutic relationship; however, she sent him a letter inviting him to resume treatment. He accepted.

Although she set behavioral boundaries, shortly after resuming treatment the patient's provocative and hostile behavior escalated. Within a couple of weeks, he self-terminated treatment. His hostility was focused on the psychiatrist's lack of responsiveness to his daily emails and voice mail messages, which included combinations of angry, lovelorn, apologetic, and sexually suggestive statements. For the next five months, the patient would engage in therapy for a few weeks, self-terminate the therapeutic relationship, then return after about a week. At every first appointment following the terminations, the physician attempted to set patient behavioral boundaries.

On November 15, 2019, the psychiatrist finally concluded the patient would be better served by a different psychiatrist. She sent the patient a letter terminating treatment, in which she listed the disruptive events, numerous self-terminations, and the patient's inability to control his impulses over the past year. After another month of emails and phone messages, the patient sent the physician a letter detailing his grievances and requesting his treatment records. The psychiatrist responded with an email describing how the grievances were unfounded or based on a false narrative. This resulted in a barrage of hostile emails and letters from the patient. The psychiatrist reported the matter to her insurance carrier, as it appeared the patient was contemplating filing a lawsuit, which he did 10 days later.

The patient's complaint alleged the psychiatrist had violated the standard of care in various ways, including:

- Making sexually suggestive remarks.
- Using a counselling method that would encourage the plaintiff to develop an unhealthy psychological dependence on her.
- Failing to explain and provide treatment for the "transference" that occurred during therapy.
- Failing to refer the patient to a different psychiatrist in a timely manner.

DISCUSSION

The defense of this case was complicated by the psychiatrist's limited contemporaneous medical record documentation of the details of the patient's disruptive behavior. In contrast, the patient created a contemporaneous narrative through extensive correspondence, which, although false, was detailed and consistent with the allegations in the lawsuit.

The psychiatrist and patient had significantly different memories of what had occurred during treatment. According to the patient, he legitimately concluded the psychiatrist was interested in a romantic liaison because she went out of her way to be flirtatious and seductive, in addition to frequently complimenting his fitness and beauty. He admitted to grabbing his erect penis and embracing the psychiatrist. However,

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he described his actions as flirtatious and appropriately responsive to the psychiatrist's provocations. He reported being completely unprepared for the psychiatrist's threat to call building security in response to his "teasing" about removing his clothing. He felt victimized and abandoned when the psychiatrist "turned on him." Later, when he reviewed his psychiatric records, he became angry at the unappealing way the psychiatrist had characterized him. The psychiatrist testified that the patient's behavior occurred with no provocation on her part. She repeatedly told the patient to stop his flirtatious and eroticized behavior and advised him that his behavior was an inappropriate distraction that was counterproductive to therapy.

Standard of care reviews were positive. However, experts questioned whether the patient could fully benefit from treatment with the number of terminations and reinstatements of treatment. The psychiatrist also admitted to defense team members that she should have terminated treatment earlier, both for the patient's and her own well-being.

Although the psychiatrist's documentation in the patient record was sparse, on numerous occasions she defended herself against the patient's allegations in correspondence to him. Extensive written responses to dissatisfied patients usually end up in the hands of an attorney and, if legal action takes place, they can complicate the defense. It is particularly important to cease communications with the patient following termination of treatment, as the relationship can be reinstated if medical advice continues to be given. In this case, once she contacted her insurer, the psychiatrist was advised to refer any further correspondence from the patient to her assigned defense counsel. Defense counsel ultimately obtained a cease-and-desist order to stop the patient's harassing letters, emails, and voice mail messages.

RISK REDUCTION STRATEGIES

Preparation is the key to successfully addressing disruptive patients. Setting expectations for patient behavior at the beginning of the physician-patient relationship can signal to patients that disruptive behavior will not be tolerated. However, in many cases, giving patients a "second chance" pursuant to an office policy and protocol can be appropriate. Ideally, intervention with a disruptive patient should occur early, before problems escalate. If rehabilitation fails, the patient's record should contain a sound basis for their termination. Consider the following strategies:

CLINICIANS

- Start behavioral rehabilitation with a patient meeting during which you can 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 letter or patient behavior agreement that memorializes the expectations and patient agreement.
    - Give the patient an opportunity to ask questions and clarify terminology.
    - Have the patient sign and date the agreement and provide the patient with a copy.
  - Identify the consequences of breaching the agreement (e.g., termination).
- 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.

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RISK REDUCTION STRATEGIES continued

- When appropriate (e.g., when a patient exhibits sexual attraction to you) transfer the patient to a different clinician.
- Document the patient's progress with rehabilitation compliance or failure.
- Terminate the patient when appropriate (e.g., when the physician-patient therapeutic relationship has been irreparably damaged, when the patient's behavior threatens your well-being, when the patient sexually harasses you).

OPERATIONS

- 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 the types of behavior for which the office has a zero-tolerance policy, including patient-initiated sexual harassment. It should also describe the use of behavioral agreements and/or behavioral warning protocols, and the fact that patients may be terminated from treatment for disruptive conduct.
  - Include a "Patient Rights and Responsibilities" section. "Patient Rights" might include the right to respectful and courteous care, the right to receive answers to clinical questions in a way they can understand, and the right to privacy and confidentiality. "Patient Responsibilities" can address treating physicians, healthcare professionals, staff, and other patients with courtesy and respect.
- Create behavioral rehabilitation policies and protocols, including warnings or behavior agreement protocols, and termination policies.
  - Intervene early, before problems escalate.
  - Provide algorithms[36] to simplify decision-making and ensure safety.
  - Establish the number of times the patient will receive warnings prior to violating a behavior agreement.
  - Train staff on patient behavioral policies and protocols.

PATIENT BEHAVIOR TOOLS

Viglianti, EM., et al.: Decision-guiding algorithm for physicians who experience patient-initiated sexual harassment and abuse[37]
An algorithm to guide clinicians in balancing their obligation to provide effective and appropriate care with their need to work in a safe and respectful environment

ProAssurance: Download: Sample Patient Behavior Agreement[38]
A sample document setting out patient behavior expectations and the results for not meeting them

ProAssurance: Patient Warning Letter[39]
A sample form letter used to warn patients that their failure to comply with behavioral rules has put them at risk of being terminated

TERMINATION OF TREATMENT RESOURCES

NORCAL Group: Termination of the Physician-Patient Relationship: Breaking Up Is Hard To Do[40]
Claims Rx article presenting case studies and risk reduction strategies associated with termination of treatment

ProAssurance: Terminating the Physician-Patient Relationship[41]
Two Minutes: What's the Risk? video addressing key considerations for deciding to end a patient relationship

ProAssurance: Withdrawal from Care or Termination Letter[42]
Sample termination letter appropriate for adaptation

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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 failures and clinical failures (unanticipated outcomes) share elements but should be distinguished in policies and protocols. Both involve patient dissatisfaction with the outcome of a healthcare encounter. Errors are inevitable, but long-term patient dissatisfaction, lawsuits, and employee distress can be prevented. Some examples of service failures are long patient wait times, last-minute appointment cancellations, dirty restrooms, poorly lit parking lots, and unfriendly clinicians or staff. Service recovery may involve listening to an upset patient, making amends, having the CEO send a letter of apology, and giving free parking or meal vouchers.[43] An unanticipated outcome is a result of treatment that differs significantly from what was anticipated. An example of an unanticipated outcome is a colon perforation during colonoscopy. 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 patient injury caused by a medical error. Managing dissatisfaction caused or contributed to by the patient (e.g., arriving too late for an appointment requiring rescheduling) will be different than managing patient dissatisfaction due to an injury caused by a member of the healthcare team (e.g., retained sponge). Research indicates that good service recovery can turn a frustrated, angry patient into a loyal one who is more likely to comply with treatment recommendations. Unanticipated outcome programs (such as Communication and Optimal Resolution (CANDOR[44]) can reduce the likelihood of malpractice suits, medical board reports, and negative online reviews.[45,46]

HEALTHCARE SERVICE RECOVERY RESOURCES

Service recovery refers to making things right following a service failure. There are a variety of healthcare service recovery resources available online, including:

AHRQ: Strategy 6P: Service Recovery Programs[45]
How to handle incidents to ensure patients feel their concerns have been addressed and that the organization values them

American College of Healthcare Executives: Fixing Healthcare Service Failures[43]
Strategies for service recovery and service failure prevention

ProAssurance: Patient Complaints[47]
Two-minute video addressing strategies for responding to a patient complaint

UNANTICIPATED OUTCOME AND APOLOGY RESOURCES

ProAssurance: Disclosure of Adverse Events[48]

AHRQ: Communication and Optimal Resolution (CANDOR) Toolkit[49]
Strategies for responding to unanticipated outcomes in a timely, thorough, and just way

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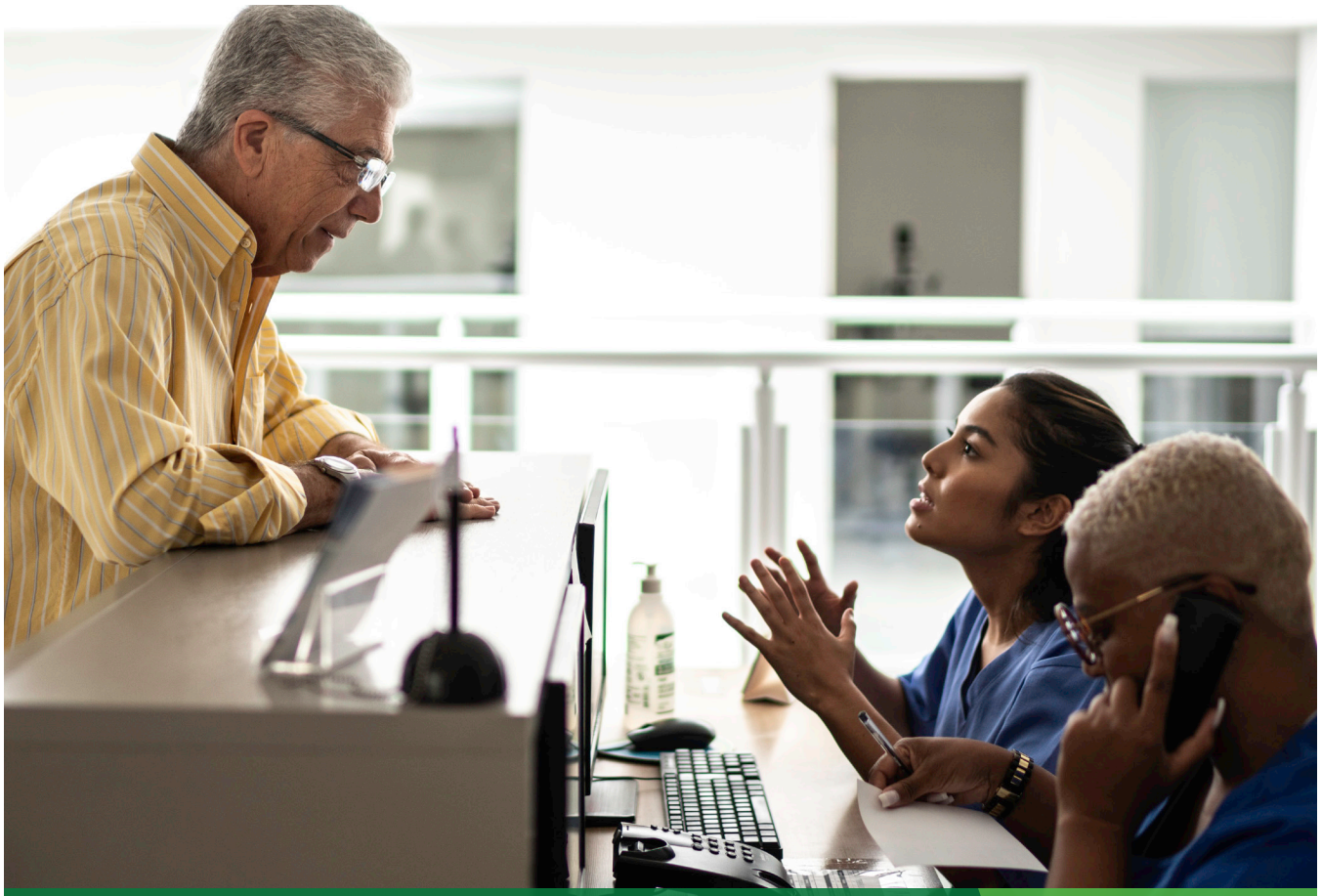

Disruptive Patient Behavior:
Mitigation and Management Strategies

CONCLUSION

Disruptive patient encounters are inevitable. They are risky from a workplace safety, patient safety, and professional liability standpoint. Successful management of an incident depends on developing the skills necessary to recognize risks and keep 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 nonviolent, disruptive patient may be the easiest way to respond to an incident, there may be a better strategy. If the behavior is the result of dissatisfaction, it may help to understand the patient's complaint, empathize, and apologize. Then reestablish behavioral expectations for moving forward in the physician-patient relationship.

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ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.

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