

Handling Difficult Patients

A Guide for Staff



Handling Difficult Patients:

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HEALTHCARE
SAVING



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Richard A. Bryan, BSN, RN, CCM, is the director of risk management, safety, and security at Overlake Hospital Medical Center in Bellevue, WA. Bryan has more than 10 years' experience in medical-legal consulting, case management, and risk management. He has provided consultative services across the western United States to insurance companies, municipalities, government agencies, employers, attorneys, and health care facilities on a variety of medical-legal, case management, risk, and health-related issues.

Spanning more than 20 years, Bryan's health care background includes staff and management roles in medical-surgical, cardiac surgery, critical care, and emergency nursing in both civilian and military settings. In addition to his duties at Overlake, Bryan continues his active nursing practice at a rural hospital emergency department. He also serves as a commissioned officer in the United States Naval Reserve.

Linda Childers

Linda Childers has more than 15 years' experience working as a professional communicator. Five years ago, she founded her own company, Childers Communications, a Northern California-based communications firm.

Before starting her company, Childers served as public information officer for Kaiser Permanente in one of its largest service areas where she produced a number of publications for both Kaiser Permanente members and medical staff.

Childers writes about health care issues for a variety of hospitals, health plans, and other health care organizations. Her articles have been published in *NurseWeek*, *Minority Nurse*, *Healthplan*, *the San Jose Mercury News*, *Oakland Tribune*, *Contra Costa Times*, *ePregnancy*, *Fit Style*, and the *Farmers' Almanac*.

Childers began her writing career while still in high school, serving as a columnist for a major newspaper in the San Francisco Bay Area. In addition to being published in many local and regional publications, she has written many award-winning corporate publications. Linda holds a bachelor's degree in mass communication from California State University-Hayward.

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Learning objectives

Upon completion of this handbook, learners will be able to

- identify patient populations that are often considered difficult for organizations
- describe the benefits of early identification and effective management of difficult patients
- practice verbal and nonverbal techniques for de-escalating anger
- list restraint alternatives for patients at risk for falling and patients who become anxious or agitated
- identify best practices for dealing with patients' families
- identify proper documentation methods

Intended audience

Nurses in all settings

Defining difficult patients

The word “difficult” is often mistakenly reserved only for patients or families at your facility who become confrontational with staff.

Although these patients can potentially threaten your safety and are a source of stress for you and your fellow care providers, they represent just one type of difficult patient that your organization deals with every day.

Patients who an organization may consider difficult are more than just those who negatively effect staff satisfaction. Difficult patients are also those who require increased resources, have a greater risk for negative encounters and outcomes (which could lead to future litigation), and tend to have prolonged lengths of stay.

Who are these patients? The following patient populations typically represent a large portion of the patients who can potentially put a strain on your organization:

1. The elderly
2. Immigrants/migrants
3. Individuals with chronic mental illness/substance abuse

To successfully handle difficult patients, you must assess and identify the challenges they pose early on and use proactive strategies to minimize negative outcomes.

Identifying and dealing with difficult elderly patients

Elderly patients can become increasingly problematic when taken out of their environments and placed in institutional settings, be it an acute or long-term care facility.

Every effort must be made to ensure that these patients are adequately assessed and that steps are taken to prevent injury. For example, be wary of the following risks associated with the elderly:

- Falls
- Wandering/elopement
- Dehydration and skin breakdown
- Medication errors
- A medically induced worsening of their confusion

Communicate with this vulnerable population and their families to accurately assess their risks and solicit assistance in managing these patients during their hospitalization. Identification of specific needs, habits, communication styles, response to medications, and verbal cues will decrease the likelihood of negative outcomes.

Frequent checks accompanied by offers to assist in using the toilet, provide hydration or nourishment, and reassurance may reduce the patient's anxiety and accompanying agitation. Systems to prevent patients from wandering may also be beneficial. These may include

bed alarms, wander alarms that sound when a patient exits or attempts to exit a particular door, or controlled access units.

These risks have potentially devastating consequences, and prevention efforts frequently require the commitment of extra resources.

Immigrant/migrant patients: Improve your cultural competency

One of the most significant issues in dealing with the immigrant/migrant patient population is overcoming language barriers to health care. A language barrier could be to blame for a patient's anxiety or noncompliance with a treatment plan. Language barriers also affect critical care cases and can create problems regarding end-of-life/withdrawal of life support issues.

Beliefs and opinions regarding these decisions vary with regard to some of the new immigrant/migrant populations for which you are caring. This variety may include appropriateness regarding the discussion of and planning for death, informing patients that they are dying, and the roles of individuals, family members, and physicians relative to end-of-life discussions.

These scenarios can highlight a lack of cultural competency that often leads to misunderstandings between families and hospital staff who care for the patient. This will ultimately impede care, delay decisions, and affect the physical health of the patient and the emotional well-being of the staff.

Cultural competency

In addition to providing effective and accurate interpretation services, your organization and its staff must make cultural competency a priority.

The key to cultural competency is providing a safe environment for your immigrant/migrant populations. Know what situations and settings may make them uncomfortable. For example, consider a mother who must explain sexual or menstrual dysfunction via translation through her young child. This is an uncomfortable situation in any culture, yet this occurs daily in many facilities.

Here are some strategies for improving communications with your immigrant/migrant patients:

- **Focus on understanding.** Entering into a situation where you understand cultural bias and misunderstandings will allow for some degree of flexibility in perceptions and delivery of care. Understand that the presenting complaint may not necessarily be what is actually wrong. Remember that trust is not developed overnight. Being thrust into a situation where everyone is different than you would make even the most trusting of us wary.
- **Acknowledge differences.** Many immigrants can quickly adapt to the ways of North Americans, including having a functional command of the language. Yet caregivers who deal with a particular population on a regular basis often fail to learn even the basics of their culture or language. Anticipate cultural and communication problems and be proactive in

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your approach to dealing with them. If problems arise, good communication is integral. Use of a translator in these circumstances is best done in person with someone you trust. The translator's ability to translate without interpretation is essential.

Identifying and dealing with the chronically mentally ill and substance abusers

Both the mentally ill and the addicted patient populations require a significant amount of you and your fellow health care providers' time and emotion

These populations' disorders decrease the likelihood that they will follow treatment regimens and long-term treatment plans. This often results in frequent relapses and hospitalizations. Staff may find themselves working with the same difficult patients month after month.

The patients in these populations often have personality conflicts that may emerge as confrontational styles, manipulation, dishonesty, and mistrust. In all of these instances, staff have to work past their personal biases and frustrations to ensure that appropriate treatment is provided.

Assessing a patient's mental status

Early assessment of patients' mental status may help you more effectively manage their care and potentially prevent problems.

Watch out for the following common disorders and signs/symptoms when patients present in your facility:

- **A patient who is depressed** may have no appetite, mention a loss of interest in pleasurable activities, withdraw from others, and have frequent sleep interruptions
- **A patient who has a borderline personality disorder** may exhibit manipulative behavior, pit one staff member against another, direct his or her care the way he or she wants it to go, and feel that he or she is always right and staff are always wrong
- **A patient who is bipolar** may show signs and symptoms of depression coupled with instances of boundless energy; his or her ability to focus will be intermittent

Assessing suspected substance abusers

A patient who presents to the emergency department (ED) with an alcohol—or another substance—abuse problem is not likely to discuss his or her addiction or abuse problems openly with you. During your assessment of the patient, he or she could be intoxicated, in acute withdrawal, or in no apparent distress at all.

Look for the following signs and symptoms to help better identify these patients:

- **Needle marks**—Substance abusers who inject drugs will typically present with needle marks. These marks can be on any part of the body, but typically on the arms. Also be aware of patients who have abscesses or infections as a result of using dirty needles.

- **Erratic behavior**—When you entered the room did the patient quickly move from watching television to lying in bed, moaning and groaning? Was the patient in pain one moment, then ask to go smoke a cigarette the next? These behaviors are not typical for someone who is in acute pain.
- **Tweaking**—Especially common for patients who abuse methamphetamine, “tweaking” is the way health professionals describe a patient’s difficulty focusing, dilated pupils, and jerky body movements.



CASE SCENARIO #1

Q A patient presents in the ED complaining of back pain. The patient has no obvious injury or broken bones that seem to support his or her vague complaints about pain. What signs and symptoms can you look for that may indicate this person has a substance abuse problem?

A Observe the patient closely. Look for needle marks, erratic behavior, and evidence of “tweaking.” These may give you early warning that you are dealing with a volatile patient who may need additional resources and more complex case management strategies.

Benefits of effectively managing difficult patients

The benefits of early identification and effective management of these difficult patient populations are clear. You can

- reduce the additional strain these patients place on your time and your organization's resources
- decrease the risk for negative encounters and outcomes
- avoid prolonged lengths of stay
- decrease the likelihood of staff dissatisfaction

De-escalating anger in difficult patients

Anger can present itself in many different ways within your organization—patients' complaints and criticism, disgruntled former employees, and frustrated families are just a few. It is essential that you are equipped with the techniques to prevent that anger from escalating into a violent confrontation.

Recognize that de-escalating anger begins by maintaining the proper distance (3–6 feet) from patients who have a history of violence or who exhibit aggressive behavior. Project a calm attitude and active listening skills, acknowledge that the patient is upset, and ask for the patient's recommendation to correct the problem.

Verbal techniques

The following are several verbal techniques with which you should be familiar:

- **Listen to the patient and respond with empathy.** Listen to what the patient is saying and do not interrupt. Try to validate his or her feelings. Most patients will calm down once they are allowed to vent their frustrations or concerns. Interrupting/denying a patient's feelings can make the situation worse. When the patient pauses, calmly say something such as, "I understand you are upset." Remain nonjudgmental, show empathy, and let the patient know you want to address his or her concerns.
- **Be aware of your paraverbals.** Paraverbals are the qualities within your verbal techniques and include the tone, volume, and rate of speaking with which you address the angry patient. Remember: An upset patient is beginning to lose rational thought, so he or she isn't focused on your actual words. A nurse's tone of voice should be calm, and nurses should avoid sounding impatient, disgusted, or sarcastic. Speak clearly and slowly in a moderate tone of voice. Speaking too fast or too slow conveys agitation and loss of control. Also, by speaking calmly and clearly, you are more likely to be heard.
- **Use the patient's name.** Use names respectfully when talking with patients. This can help diffuse their anger and ensure them that you are genuinely interested in resolving their concerns.
- **Set nonnegotiable limits.** Give patients clear choices and consequences for their actions. This provides information to the patient for making a conscious choice. For example, to a verbally abusive patient you might say, "If you refrain from using profanity, we can discuss your concerns. If not, this conversation is ended." Choices need to be clear, concise, and enforceable.

Nonverbal techniques

Believe it or not, your nonverbal communication techniques are the most important aspect of your de-escalation strategies. Studies show that when in a rational state of mind, a person's body language conveys about 55% of his or her message and verbal communication only about 10%. When you de-escalate patient anger, your body language may be communicating more to your angry patient than are your words. With that in mind, read the following guidance:

- **Respect a patient's personal space.** Personal space is the area around a person in which he or she feels safe. For most patients 2–3 ft should be a safe parameter. But allow 3–6 ft for patients who have a history of exhibiting aggressive behavior. Entering an upset person's personal space can intensify his or her emotions. Remember: An angry patient may already feel that he or she is losing control by simply being in the hospital.
- **Maintain an open stance.** Assume a stance in which you slightly turn your body at an angle to the patient while keeping your hands open and in plain view. Angry patients will perceive this stance as less threatening. Refrain from crossing your arms or pointing fingers, as both can send out a negative message and may be seen as threatening.
- **Maintain appropriate eye contact and facial expressions.** A nurse's face and eyes convey a direct message to the patient. Maintain general eye contact, but do not stare at the other person. Also, be aware of cultural habits within your patient popu-

lation. Some ethnic groups consider it inappropriate to look directly at another person when he or she is upset or being disciplined. Your facial expression should be serious, but not angry or fearful. Convey concern and control. You do not want patients to read into your facial expression that their condition is more serious than they perceive, or that you don't care about their situation.



CASE SCENARIO #2

Q

You enter into an exam room to assess a patient who is clearly agitated. He or she avoids answering any of your direct questions with clear answers. Over the course of your “conversation” the patient becomes increasingly volatile. The patient is now very angry and begins to raise her voice. How do you solve this patient’s problem safely?

A

A common misconception by nurses is that this is the point that they need to solve this patient’s problem. However, this is when you begin to use de-escalation techniques such as speaking with empathy, being aware of your paraverbals, keeping a safe distance, and setting nonnegotiable limits with the patient.

Using restraints with difficult patients

Nurses have long walked a fine line attempting to balance the care of patients who are at risk of harming themselves or others. Creating an environment that offers patients both dignity and safety isn't an easy task. However, it is incumbent upon all health care professionals to take steps to protect their patients and colleagues. One of the first methods that comes to mind is restraints.

This practice of using restraints, though popular in the past, has fallen out of favor. Studies and anecdotal evidence have demonstrated that restraint use with the difficult patient populations we've discussed was not conclusively effective. In many instances, it resulted in a worsening of agitation, injuries, and even death.

Today's restraint culture

Restraint use has become very labor intensive, both from a perspective of staff requirements for applying and monitoring the restraints and also from a perspective of physician involvement with the ordering, initial and ongoing assessment, and termination of restraint use.

Equally difficult and time-consuming is the issue of restraint use when it is either presented by the family or required by patient behaviors. Many families fail to understand why caregivers do not restrain, or "tie down," their loved ones. They often become angry and/or threaten future claims or legal action should a fall or injury occur.

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Early education and continued communication are keys to overcoming this potential landmine. Also consider the following when restraints must be applied:

- Staff should communicate, from beginning to end, the rationale for restraint use
- Staff should also relate what alternatives have been considered and time frames for restraint use
- Most importantly, staff should follow your institution's policies and document the entire process

Protecting yourself with documentation

Thorough documentation is one of your organization's best protections against accusations of improper restraint usage and potential litigation. Your clear and complete documentation of these episodes will also serve as the foundation for your quality improvement efforts.

Some organizations choose to record this information in the patient's record, while others use a separate restraint log or flow sheet. Regardless of the method, documentation must be clear and complete. Keep in mind that these records do not exist merely for caregivers or other facility personnel. Your documentation can be submitted as evidence in a court of law.

Alternatives for patients at risk of falling

Facilities that are moving away from traditional restraint use to prevent falls have reported a decrease in the number of patient falls and the severity of injuries to patients who fall as a result of climbing over or through bed rails.

The following are some fall-prevention strategies for the elderly and other at-risk patients:

- Identify patients who are at risk of falling by affixing a star (i.e., “falling star”) to their wheelchairs and outside their rooms to notify staff that they are a fall risk.
- Purchase nonslip sole slippers and provide them to patients for free.
- Invest in gripper pads, like those often used to line cabinets in your home. By putting this type of pad in a patient’s wheelchair or bed, it can reduce the chances of the patient sliding out and falling to the floor.
- Think about where you place bedside commodes. Placing a bedside commode near the patient so it can be easily and safely used when needed may cut down the potential for falls at your facility.
- For patients who are incontinent, set up a care management plan in which the patient is taken to the toilet every two hours when awake. This should reduce the patient’s attempts to get to the restroom on his or her own.

Alternatives for patients who become anxious or agitated

When dealing with patients who become anxious or agitated, nurses must first rule out the possibility of infection. If a patient with a neurological condition such as Alzheimer’s has a sudden cognitive or behavioral change, one of the first things to consider is an acute illness.

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Neurological diseases don't cause abrupt changes in a patient's condition, so a sudden change signifies that something else is happening. The only cues that they are in pain may be to act out—especially for nonverbal patients.

Facilities that have tried to reduce restraint use for patients who become anxious or agitated have used some of the following strategies:

- **Planned activities held throughout the day can be especially effective in reducing the effects of “sundowning.”** Sundowning is a term experts have used to describe the period of increased confusion, anxiety, agitation, and disorientation that begins at dusk and continues through the night that affects many Alzheimer's patients. Many facilities have found that a healthy schedule of daytime activities keeps the minds and bodies of patients occupied and discourages afternoon napping that may contribute to anxiety at dusk and sleeplessness.
- **Make “confusion bags” an integral part of your unit.** These bags are full of things to keep confused patients' hands busy: balls of yarn, small hand-balls, Play-Doh, zippers, or any other item that is safe and keeps patients' minds occupied. These tasks have shown to reduce patients' level of anxiety.
- **Utilize music therapy.** Music has been shown to have a calming effect on many patients. Keep headphones and radios at hand to use on patients who become anxious or agitated.

Documenting the difficult patient experience

Nurses need to be aware of the increasing number of lawsuits filed by difficult patients who became dissatisfied with their care. This, coupled with the fact that the country's nursing shortage is forcing nurses to take on more responsibility and accountability for patients in the acute care setting means that nurses' chances of being named in a lawsuit are increasing.

Protect yourself and your facility from legal troubles with good documentation

Charting difficult patient situations or those confrontations that may lead to possible legal ramifications demands good judgment on the part of nursing staff. Clear documentation reduces liability and can be an indispensable performance improvement tool for your staff and organization. Abide by the following to keep your organization out of legal hot water:

- **Don't refer to staffing problems**

If a nurse feels that inadequate staffing affected a patient's care, he or she should follow the hospital's policy for reporting the problem. Appropriate actions include writing a confidential memo, completing an incident report, or notifying his or her unit supervisor and making a personal note—not in the chart—that he or she called the situation to the attention of the nurse manager.

- **Avoid wording that implies that errors were made**

When charting, nurses should avoid words that imply that errors have been made. Words such as "accidentally" or "unintentionally" can easily be interpreted as admissions of errors. If an order is

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not carried out correctly, nurses should indicate in the chart what happened and what actions were taken.

- **Include behaviors that interfere with treatment**

Nurses must document all patient behaviors that interfere with medical treatment and must include in the chart that patients have been notified of the possible consequences of their actions. For example, document that you explained to the patient that if he or she refuses to use a walker for assistance, the likelihood of a fall and subsequent injuries increases.

- **Exclude your opinions**

Charting is a place for facts, not the opinions of nursing staff. If a nurse is unhappy with his or her patient, physician, or facility, the chart is not the place to vent. Charting criticism make nurses appear less credible. If a nurse has issues regarding staffing or the patient's care plan, concerns should be addressed through the proper channels, not in a patient's chart.

- **Record unauthorized possessions**

Nurses should document any unusual or unauthorized items that the patient possesses. Such items may include alcoholic beverages, tobacco, heating pads, medications brought from home, or devices that should be checked by the biomedical department before use. Describe each item in a narrative note and what action you took to dispose of the item.

- **Only use approved abbreviations/shorthand**

Nurses should never use shorthand or abbreviations that aren't widely used in the medical community or easy to understand. One of the JCAHO's seven National Patient Safety Goals (NPSG) requires hospitals to standardize how staff abbreviate or symbolize expressions throughout the organization, including developing a

list of confusing abbreviations, acronyms, and symbols that staff should not use. To this end, the JCAHO has developed a minimum list of dangerous abbreviations, acronyms, and symbols for you to comply with. The 2004 NPSG went into effect January 1, 2004.

- **Record unusual incidents**

Nurses should always chart all their observations, actions, and the patient's response to medications and treatment. List any unusual incidents, such as if the patient becomes aggressive or combative, and subsequent safety precautions taken to protect the patient. Patients perceived as "difficult" may be reacting differently because of the introduction of a new medication or a drug interaction.

Dealing with difficult families

Some are fearful and some are angry because of a previous encounter with a health care professional. The reasons why patient families become difficult are as varied as the families themselves.

Many patients and their families seek legal representation because they feel that the health professionals showed no concern or warmth, wouldn't listen, wouldn't talk, or wouldn't answer questions.

Analyzing your communication environment

Take a moment to analyze your environment. Think about what kind of relationship your organization has with patients' families. Make sure all staff in your organization are doing all they can to effectively communicate and apply good customer service principles to their interactions with patients' families.

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The following are some common situations and interactions within your organization that can contribute to patients' families becoming difficult and may demonstrate your vulnerability to difficult litigation:

- **A poor office experience**

Long waits, especially those without an apology or frequent check-ins, frustrate patients and their families. This may be an opportunity for an attorney to show a disorganized or hurried staff.

Make sure the communication climate is set from the moment a patient or family enters your facility. Did the receptionist make eye contact and say hello to everyone? When a patient or family member is called from the waiting area, does the nurse simply bark out a name and then turn around, expecting the person to follow? Does your facility have a method for ensuring that no patient or family member is waiting too long?

- **Family concerns met with lack of respect**

Pay attention to how you speak to the family. Never talk down or speak in a judgmental way. If you often interrupt patients or their families, it may appear as if you are taking their claims lightly.

- **Crucial developments or information are not delivered to the family**

The physician scheduled to see the patient is replaced at the last minute by a colleague. This situation is not explained to the patient's family. A complication or error occurs during the exam. When the new physician speaks to the family members, their first

reaction is confusion, then anger. This type of oversight will quickly transform your communication environment from one that is open and honest to one that is characterized by mistrust.

- **Informed consent is mistaken for true understanding**

A nervous patient may give his or her informed consent for a procedure, but not understand what it is that the physician is communicating. The next day, the patient or his or her family could call the office and ask for more details. The staff may not have time to walk the patient through all the information again. The patient or family member cannot get his or her questions answered and becomes angry when a complication occurs. This is an opportunity for a lawyer to show how the patient was denied important information.

Conclusion

Difficult patients and difficult families are more than just those who become upset with care and lash out against staff. Although staff dissatisfaction is a significant consequence of dealing with difficult patients, it is not the only one. Frequently, your difficult patients are those who require increased time and resources, are likely to have a greater risk for negative encounters and outcomes, and tend to have prolonged lengths of stay.

Identifying these patients as early as possible and using some of the proactive strategies discussed in this handbook are essential to effectively deal with difficult patients.

Final exam

- 1. Which of the following groups typically consists of patients who often require additional resources, have a greater risk for negative encounters and outcomes (which could lead to future litigation), and tend to have prolonged lengths of stay?**
 - a. The elderly
 - b. Immigrants/migrants
 - c. Chronically mentally ill/substance abusers
 - d. All of the above

- 2. A patient's anxiety or noncompliance with a suggested treatment plan may be attributed to a staff member who misunderstood certain beliefs and opinions that the patient's native culture may have. Situations like this highlight a staff's lack of _____?**
 - a. Good training
 - b. Documentation habits
 - c. Cultural competency
 - d. Experience

- 3. Which of the following are benefits of early identification and effective management of difficult patients?**
 - a. The additional strain these patients place on your time and your organization's resources is reduced
 - b. The risk for negative encounters and outcomes decreases
 - c. The likelihood of staff dissatisfaction decreases
 - d. All of the above

4. A nurse initiates anger de-escalation techniques by maintaining a safe distance (3–6 ft) from the patient and _____.

- a. Secretly notifying security personnel that a problem patient has been identified
- b. Getting control of the conversation by changing the topic, diverting the patient's attention to unrelated details
- c. Bringing in another staff member to help gain leverage in the argument
- d. Projecting a calm attitude and active listening skills, acknowledging that the patient is upset, and asking for his or her recommendations for correcting the problem

5. Nurses should always be aware of their paraverbals—tone, volume, rate at which they speak—when de-escalating anger in patients. Nurses should avoid sounding

- a. Impatient
- b. Disgusted
- c. Sarcastic
- d. All of the above

6. Facilities that are moving away from traditional restraints often use which alternative to help prevent elderly or other patients at risk for falling from slipping out of wheelchairs or armchairs?

- a. Plastic waist restraints
- b. Gripper pads, such as the ones used in cabinets in your home
- c. Limits on wheelchair/armchair use
- d. Constant nurse supervision

7. Planning activities to be held throughout the day can be especially effective in reducing the effects of “sundowning.” Sundowning is a term used to describe what?

- a. A period of increased confusion, anxiety, agitation, and disorientation beginning at dusk and continuing through the

night that affects many patients with cognitive disorders such as Alzheimer's

- b. A patient's increased likelihood to fall at night when facilities are less well-lit than in the daytime hours
- c. A period of quiet time and reflection that occurs after visiting hours, when a patient mentally reviews the day's visitors or lack of visitors
- d. The first night shift, when staff nurses are typically less responsive to patients at risk for injuring themselves or others

8. One of your best protections against accusations of improper restraint usage and potential litigation is ____.

- a. Proper technique in applying restraints
- b. Several policies pertaining to restraint use
- c. Well-informed staff
- d. Clear and complete documentation

9. It is important to remember that good documentation can improve future practices in handling difficult patients at your organization and may protect your organization from malpractice claims if your charting is ever ____.

- a. Stolen by a patient
- b. Sanctioned by a state nursing board
- c. Submitted as evidence in a court of law
- d. None of the above

10. Your first line of defense against difficult behavior of a patient's family member and the resulting litigation is ____.

- a. An open, honest, and respectful communication environment
- b. A thorough complaint procedure policy
- c. A strong risk management department
- d. A low nurse-to-patient ratio

Answer key

1. D
2. C
3. D
4. D
5. D
6. B
7. A
8. D
9. C
10. A

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