

## ***Certification Test For Students***

### **A. Precipitating and Predisposing Factors of Violence Risk**

1. Violence is defined as an act that produces harm or destruction.

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2. List at least three predisposing factors for violence.

- a.
- b.
- c.

3. List at least three precipitating factors for violence.

- a.
- b.
- c.

4. The most important aspect of managing disturbed behavior is prevention.

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5. It is safe to assume that there is minimal risk of violence with medical patients.

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6. A past history of violence is usually not a good indicator of potential violence.

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7. List three characteristics of a person most likely to exhibit violent behavior.

- a.
- b.
- c.

8. Every person given the right set of circumstances, in an effort to regain control of the environment, has the potential for violence.

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9. Factors leading to violent behavior can be precipitated by the environment or by the patients themselves, but can never be precipitated by the staff.

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10. Mental disorders that are likely to have violent behavior as part of their clinical presentation include schizophrenia, PTSD, organic disorders, and affective disorders.

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11. Doing an environmental assessment for potential weapons is an example of violence prevention, performed when a known violent patient is in your area.

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12. A thorough evaluation of the patient's physical and family/social history must be done on every patient before you attempt any type of intervention for violence.

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13. Individuals who are admitted to a hospital often experience fear, anger, or frustration. List at least three factors that elicit these feelings.

- a.
- b.
- c.

14. To be a safe care provider, you must learn to ignore your gut feelings of impending violence until your patient provides clear, objective data demonstrating violence.

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15. The best defense against malpractice claims is providing clear documentation of patient care.

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16. Every violent incident should be evaluated and debriefed with staff and patient soon after the incident occurs.

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17. Critiques should always be designed to identify faults with the intervention process.

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## **B. Verbal & Non Verbal Interventions**

### **True or False**

1. Verbal communication is more important than non-verbal communication when dealing with a crisis situation.

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2. Verbal intervention should be used only after physical control has been established with a hands-on technique.

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3. Your team should never attempt to talk to a potentially violent patient because you may get hurt.

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4. The crisis intervention team should always convey calmness and control when dealing with a high risk patient.

T F

5. Never encourage potentially violent patients to ventilate as it causes them to escalate.

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6. Alternative interventions for handling anger include walking, using a quiet room, verbalizing anger towards the V.A., and physical exercise.

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7. Touching a high risk patient is recommended as it usually has a calming effect.

T F

8. Making promises you can't keep is acceptable when it calms a patient.

T F

9. Only patients benefit from a quality environment.

T F

10. With our decreasing staff size, expecting compassion and empathy from staff when dealing with patients is unrealistic because it is too time consuming.

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11. Only staff directly responsible for patient care should receive PMDB training because they are the ones primarily responsible for talking to the patients.

T F

12. Supervisors should be primarily responsible for intervening with patients and/or their family's complaints.

T F

13. In many cases, peer recognition can be more meaningful than recognition from supervisors.

T F

14. Occasionally we may need to be actors at work and set aside our personal problems.

T F

15. We should never be expected to work with staff with whom we have conflicts, as in-house fighting presents a non-therapeutic environment.

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16. Most violent behavior occurs without warning.

T F

17. Limits should be detailed, non-threatening, and enforceable.

T F

18. Set limits on feelings and behavior.

T F

19. List the four stages of increasing patient tension (levels of anxiety) and the corresponding staff interventions for each stage.

	Patient	Staff
a.		
b.		
c.		
d.		

20. List five warning signals that indicate a person may be escalating.

- a.
- b.
- c.
- d.
- e.

**C. Personal Safety Skills**

1. List three reasons why the supportive stance is supportive:

- a.
- b.
- c.

2. List the three components to blocking a strike:

- a.
- b.
- c.

3. List the three components to get out of a grab.

- a.
- b.
- c.

### **True or False**

4. When considering a patient's personal space it's safe to stay just outside an arm's reach from the patient.

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5. When a patient is agitated he feels more comfortable when staff enters his personal space.

T F

6. The supportive stance is useful because it makes you less of a target, puts you off balance, making it easier for you to turn and run.

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7. The only two ways we can be physically attacked is punching and kicking.

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8. When blocking a strike, put something between you and the striking force.

T F

9. To escape from a grab you must first locate the person's thumb and roll away from it.

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10. When being choked from the front, raise your arms through the inside of the patient's arms and push out.

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**D. Working as a Team**

**True or False**

1. The minimum size of a crisis intervention team should always be two people.

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2. The maximum amount of people per crisis intervention team should never exceed three.

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3. Only professionals trained in psychiatry or police work should be members of crisis intervention teams.

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4. During a crisis situation, the team member with the best rapport with the patient becomes the leader regardless of his/her background.

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5. A crisis intervention team can only be effective if it has confidence in the technique and its ability to perform it.

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6. A show of force in and of itself represents a cohesiveness and coordinated approach to crisis intervention.

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7. Problems with established crisis intervention teams are best dealt with on a one-to-one individual basis, not with the entire team present.

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8. Team members' roles are not interchangeable.

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#### **D. Personal Contact Skills**

##### **True or False**

1. A crisis intervention team should be summoned as soon as patient agitation is evident.

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2. You are never expected to physically control an acting-out patient when you are alone.

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3. When using a crisis intervention team to diffuse acting-out behavior, the physician should always assume the role of team leader; and in his/her absence it should be an RN.

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4. Once a team leader is established it is still possible for a new team leader to assume control.

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5. All team positions must be assigned prior to approaching a potentially violent patient.

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6. A good example of limit setting is informing the patient, "If you don't settle down we will call the police and have you removed from the facility."

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7. A code word for initiating hands-on by the team should be standard throughout the facility to insure that it is known by everyone.

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8. The code word is not the only indicator that it is time for hands-on intervention.

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9. Hands-on intervention is applied when the patient escalates to Stage 3.

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10. The first team member to touch the patient is the person positioned at the patient's back.

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11. The team member at the back is responsible for keeping the patient standing as long as possible.

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12. Take-down should be initiated when the patient becomes tired from struggling.

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13. Once the physical intervention begins, it is not advisable to talk with the patient.

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14. Once the physical intervention begins, never attempt to switch positions.

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15. On your unit, once the patient has been taken down and placed in control, it is important to decide what action must be taken next.

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16. For this physical intervention technique to be effective, everything must go exactly as planned.

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17. In this physical intervention technique we are not trying to physically overpower the patient.

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18. After staff in high-risk areas have been trained in these techniques, it is anticipated that hands-on intervention will be used more often to prevent acting-out.

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