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Code White

Code White means a staff member needs immediate assistance due to a threat or aggressive behaviour. The threat could be from a visitor, a resident, staff member, or volunteer and could involve verbal or physical abuse. Staff members shall not be left alone with an aggressive/responsive person. There should be a minimum two staff members present, at all times, when approaching and stabilizing an aggressive/responsive person.

Aggressive behavior is best understood as a responsive behavior to exert control or to protect or defend oneself.

The first person on the scene ensures the safety of Residents by clearing the area. When staff are not able to defuse a situation and the person or property is in danger, and assistance is required, RN/RPN (or designate) will announce over the P.A. system "**Attention All Staff Code White Floor XX, Zone YY, Room ZZ**" three times. This will initiate a Team Intervention Protocol (see below).

To Acquire Assistance if staff are unable to page using the P.A. system:

- Staff are to push the call and cancel buttons on any nurse call station to request emergency assistance; pull string and cancel button at the same time on bathroom stations
- If it will not upset the individual further, yell for help/ blow whistle
- Staff involved will have to use their judgment to leave the room to get assistance or if they should stay in the room until help arrives;
- Staff should not all crowd into the room where the scene is taking place as this will likely aggravate the situation further.

If code white is called due to a physical threat by a non-resident, call 911 immediately prior to announcing code white.

Team Intervention Protocol

Using the team intervention approach when a Code White is called can considerably reduce the confusion and potential for injury in any situation. This approach assigns staff members' specific functions. Everyone involved should be able to calculate each other's actions.

A team should include four to five members, including a leader and a co-leader. The roles of each member are described below.

Response for the Team Intervention Protocol (initially 3 staff responding):

a) RN in charge (team lead):
b) RPN from the unit;
c) PSW – most senior;
d) RPN's from all East units respond but stays in background – only helps if required.

If there is a Code White called for the Great Room the following staff will respond:

a) Charge Nurse (2nd Floor RN);
b) RPN from 2E;
c) PSW from 2W – most senior;
d) RPN's from all East units respond but stays in background – only helps if required.
e) Once the resident is identified a PSW from the unit where the resident is from may be sent for.

At any time the team lead may page for additional staff, at which point the most senior PSW from each floor will respond to the Code White scene. If additional staff are paged for, 911 must also be called.

The Team Lead initially is the person involved in dealing with the situation; they could be from any department and/or classification. When the RN for the floor arrives they will slowly take over.

a) takes a 3-5 second pause once eye contact has been established;
b) is the only person talking to the resident;
c) keeps a safe distance;
d) scans resident and room.;
e) is aware of own body language;
f) may ask co-leader to take over as leader if appropriate;
g) talks only to co-leader regarding intentions;
h) may also use hand signals;
i) keeps resident informed as to what he/she is doing;
j) makes it clear to resident that they will talk once client is settled;
k) de-escalates situation and helps resident gain control;
l) continues to assess situation.

Co-Leader is the RPN from the unit where the situation is occurring, or from 2E if in the Great Room. Their role is:

a) assesses potential for violence;
b) removes everyone not involved in intervention;
c) does not interact with resident;
d) takes direction from leader regarding type of intervention to be used;
e) is the only person talking to the leader (other than resident);
f) directs physical intervention if indicated;
g) may take over role of leader if leader assigns;
h) assigns staff member not directly involved in intervention to monitor desk, hallway, elevators etc.
i) assigns staff to call for further assistance if required. (i.e. police);
j) remains at scene for entire duration of intervention.

Other employees responding to the Code White will:

a) follow direction of co-leader and will not argue with co-leader;
b) will not attempt any verbal interaction with resident;
c) assist with intervention as directed by co-leader;
d) observe interaction for feedback to other team members later;
e) follow procedures for physical intervention once decision has been made;
f) act quickly and in a co-ordinated manner to prevent injury to resident and staff;
g) remain in the corridor just outside the residents room if possible until needed (do not crowd into the room, it will only agitate the resident).

Calling 911:

a) Any staff member may call the police using 911 at any time if threatened or in a crisis situation and state address of:

519 King St. West

b) If 911 is called for an uncontrolled situation the Director of Nursing and the Director, Seniors Services must be contacted as soon as reasonable to do so;
c) If a resident has been abused please see policy ADM RES Resident Protection and Initiate Critical Incident as outlined in the Critical Incident Reporting Policy.

Guidelines for Dealing with Aggressive Behaviour

Aggressive Person's Behaviour	Staff Members Response
ANXIETY - **restless** - **fidgety** - **eye contact** - **pacing/wandering** - **voice → louder and faster**	**SUPPORTIVE** - **empathetic** - **active listener** - **friendly** - **do not rush** - **meet the person's needs if possible**
NOTE: Staff member must be alert to pick up on cues in order to intervene BEFORE the situation escalates. The staff member might not know the cause of anxiety but may see something is building up inside.	
DEFENSIVE - **belligerent** - **challenging** - **losing control** - **inattentive** - **clenched fists**	**DIRECT** - **be assertive** - **set limits** - **give clear, simple, concise directions**
NOTE: Staff member must act to avoid further escalation of next stage. Staff member must be careful not to be drawn into the conflict.	

ACTING OUT - **loses control** - **strikes out** - **intimidating**	**NON-VIOLENT PHYSICAL CRISIS INTERVENTION** - **personal safety techniques** - **GET OUT… GET HELP**
REDUCTION OF TENSION - **exhausted** - **embarrassed** - **sad**	**THERAPEUTIC RAPPORT** - **if aggressive individual is a Resident, realize that behaviour was not necessarily directed at the staff member but a possible release of tension** - **discuss incident with Resident at a later time**

Behaviour Management

Crisis can be described as an individual's inability to utilize their normal coping mechanisms to resolve a stressful situation, resulting in a change in their emotional state. This change can range from being mildly upset to being extremely agitated, and at times violent. Crisis is not reserved for the mentally ill. In fact, any individual who is facing or has faced a stressful situation is at risk of being in crisis.

Staff should keep in mind when responding to a situation that behaviours in residents with dementia/Alzheimer's are often a result of unmet needs. There is a meaning behind each behaviour and the behaviours are time limited and episodic. This may assist in deescalating the situation.

Having the ability to recognize these changes in emotional state and knowing how to respond are the most important aspects of crisis prevention. This program will assist you to prevent crisis through the use of various communication techniques. You will learn three main types of response, including:

a) Calming – used when the resident is mildly upset and can be talked through a situation by one, possibly two staff
b) Defusing – used when the resident is at risk of acting out violently but hasn't yet
c) Physical interaction – used when the situation escalates beyond just talking.

Through the use of the crisis prevention and intervention techniques covered in this program, a crisis or potential crisis can be resolved quickly, safely and effectively.

Interaction

How individuals interact with each other can play an important part in preventing aggression/behaviours. Personhood promoting interactions include:

a) Validation – supporting the emotions and feelings the person is experiencing
b) Collaboration – working together with the person to enhance his/her abilities and encourage his/her control and choices

c) Facilitation – accommodating the persons disabilities to enable him/her to do a task or activity
d) Play and celebration – encouraging spontaneity, self-expression, joyfulness and celebration just for fun
e) Relaxation – helping the person to relax and feel comfortable without making any intellectual demands.

Staff **should not** interact with residents in the following manners:

a) Infantilize – treat an adult like a baby or child
b) Label – using a term as the main way to describe or relate to a person
c) Outpace – providing information, choices, activities etc. at a pace that is too fast for someone to follow
d) Impose – force a person to do something that over-rides his/her desires or denying the possibility of a choice
e) Ignore – carrying on a conversation or an action in the presence of someone as if he/she was not there.

Calming

Calming techniques are used with residents who are mildly upset. These techniques are essential to the maintenance of a therapeutic environment, which will reduce the possibility of a crisis.

Calming is also useful when it is felt that a resident is becoming upset or angry. By reducing the resident's disturbance early, through careful listening and by encouraging him to talk, emotional upset or agitation can often be prevented. By dealing with a resident's disturbance early, you can often avoid having to control a more agitated client later.

Some cues that indicate a need for calming are the following:

a) When a resident shows signs of anxiety, arousal or anger;
b) exhibits changes in his usual behaviour patterns;
c) When the resident has faced unusual, frightening or frustrating experiences.

The goals of calming are:

a) To assess resident's current emotional state;
b) To determine what is influencing the resident's emotional state;
c) To eliminate or reduce the emotional level;
d) To prevent the resident from upsetting others.

Steps in Calming

Most residents will find it calming and reassuring when someone listens to them. Having an opportunity to vent feelings with an interested listener will often have a direct calming effect on an upset resident.

Although calming and reassuring a resident may seem simple, there are five steps, which should be followed to maximize the chances of being successful. They are discussed in more detail below and are: Observation, Preparation, Approach, Action and Follow up.

1. Observation

Before talking to an upset resident, one should always make careful observations. The more you have been able to observe a resident in the past, the more effective you will be at recognizing behaviour and mood changes. If you have been unable to observe the resident in the past, reading the chart and discussing the resident with other staff may prove to be useful.

It is important to note that not only the physical behaviour of the resident, but the verbal/non-verbal behaviour as well. A resident's non-verbal communication can tell us a great deal about what they are feeling. Due to the fact that non-verbal communication is less directly under conscious control, it is an especially good indicator of a resident's emotional state.

2. Preparation

If your observations indicate a need for calming, prepare to intervene. If you are unsure as to whether or not calming is indicated, do it anyway. The calming procedure does not take a great deal of time and the resident will likely appreciate the interest being shown.

a) Safety - Before approaching an upset resident, be sure that you are able to be seen by other staff members. Also, tell the other staff members that you are going to talk to a resident who may be upset;
b) Place - Calming is best done in a quiet, comfortable, private place. You can either ask the other residents in the area to move or take the upset resident someplace else. Always remember to tell other staff where you are going;
c) Timing - Before you can effectively calm someone else, you must be calm yourself. It is difficult to appear calm if you are in a hurry and have to rush off to do something else in a few minutes. Calming itself does not take a long time, but give yourself at least ten minutes to spend with the resident before you attempt to intervene;
d) History - If you have time, review the resident's history through talking with other staff and reading the chart. The more you know about a resident, the more successful your attempt at calming will be.

3. Approach

We have already talked about how residents communicate through non-verbal, as well as verbal cues. What is important to remember is that staff members use both verbal and non-verbal communication as well. This section covers the different non-verbal cues staff transmit to residents and how clients are likely to interpret them.

a) **Voice tone and quality, and facial expression** - When attempting to calm a resident, you want to sound calm, friendly and interested. This will help you to draw the resident out. Try to never sound harsh, angry, sarcastic or accusing. A smile will go a long way in easing the situation;

b) **Body posture** - The proper body posture should display a calm interest. Always avoid looking aggressive, intimidated or afraid. The proper stance is discussed in the physical intervention section of this booklet;
c) **Physical distance** - Sitting or standing too close to a resident can often be interpreted as an aggressive invasion of personal space. Equally important, sitting or standing too far from the resident can be misunderstood as either fear or lack of interest or trust. Try and maintain an average distance of three to four feet from the resident;
d) **Eye contact** - Eye contact should be maintained just as it would in normal conversation. Staring at the client can make the resident feel very threatened, while avoiding eye contact can be perceived as a lack of interest;
e) **Opening statement** - As you begin to approach the resident, carefully plan your opening statement. You may wish to ask the resident if he wishes to talk with a statement like "You look upset. Would you like to talk about it?". In certain situations however, you may not want to give the resident an opportunity to say no by using a statement like, "You look upset and I'd like to talk to you about it."

4. Action

Upon approaching the resident, encourage him/her to talk, and listen carefully to what is being said. The simple fact that someone else is showing an interest can often have a profound calming effect itself.

In a calming situation, the most effective communication techniques will be ones that draw the resident out, show that you are interested and show that you are listening. The following three basic techniques are particularly useful.

a) **Open questions** - Open questions are used to get a resident to open up, expand on previous statements, and talk more. These are questions that do not lead up to simple "yes" or "no" answers. They will encourage residents to explore their thoughts and feelings without feeling they are being interrogated.

   Open questions generally begin with "what", "how", "could", or "why". "What" questions deal primarily with facts, and "how" questions deal with feelings. "Could" (or "would") questions allow maximum flexibility, even allowing the resident the implied right not to answer. "Why" questions deal mainly with reasons, but should be used sparingly as they can often make a resident feel defensive.

b) **Active listening** - Active listening involves the use of responses such as "I see", "go on", or "oh yes", or gestures like a simple head nod to show someone we are listening, are interested in what they are saying, and wish them to continue. Most people require some feedback or indication that they are being listened to. Active listening allows us to give this feedback without interrupting their train of thought. Simple repetitions of a few words the resident said will also achieve this, while often prompting the resident to expand on his thoughts.

c) **Paraphrasing** - Paraphrasing is stating in your own words what the resident has just said. It is often just a simple summary of the client's train of thought. It is useful in allowing the staff member to make sure he has understood what the resident meant. Paraphrasing also shows the resident that you are really trying to understand, and therefore build a therapeutic relationship. More importantly however, it gives the resident a chance to clarify what he has said if it has been misunderstood.

These techniques are very simple, yet very effective. They should be relied upon to get the resident to talk. If you make a resident feel comfortable in your approach and physical presence, you will find that the resident will not only be more inclined to talk about how they feel and why they feel that way, but will also likely be calmer at the end of a brief talk.

During your interaction with the resident, continually observe to see whether he does in fact become calmer and less agitated. Try and determine which topics seem to agitate the client more than others.

Doing nothing is having a plan.

During your attempt at calming a resident, the specific actions you take depend on the circumstances. If there is nothing you can do about the situation that has the resident upset, you may be able to just listen and empathize. Other times, you may be able to help the resident find a suitable solution to the problem by helping him to explore alternative courses of action. If the resident's concerns are unrealistic, reassure the resident. If the resident has a reasonable request, grant it if possible. If another member of the team can more effectively deal with the resident's concerns, refer the resident to that person.

5. Follow-up

Regardless of the outcome of your attempt at calming a resident, some type of follow-up is required. Inform other staff of the resident's concerns and how you addressed them. Document carefully. If you told the resident you would do something for him, do it as soon as possible. If the resident agreed to do something for you, check back in a reasonable amount of time to see if it has been done, and offer praise if the task has been completed.

FYI- Despite your best attempts at calming a resident, there will be occasions when you are not successful, or the resident simply may not want to talk. If this occurs, let the resident be, but make it known that you will be available to talk if he wishes to do so later. Often the resident will wish to talk shortly after your first approach, or will seek out a staff member whom they may feel more comfortable with.

Defusing

Despite your best effort at calming a resident, there will be times when the calming procedures do not work and the resident will become extremely upset and/or agitated. In these situations the resident can often be very close to acting out violently. The situation

must be brought under control quickly and effectively to avoid injury to resident or staff. Non-physical intervention (defusing) should almost always be attempted first. Most often the defusing will be effective and the situation will become one of calming.

Defusing means to de-escalate situations that are close to becoming violent using verbal techniques. In these situations, the first thing you say will likely be the most critical. If you say the wrong thing the situation may very well end in some type of violence. Unlike calming situations, you will not likely have a second chance to intervene.

Defusing procedures are needed when a resident appears to be escalating or losing control, or when physical assault seems imminent. Behaviours that indicate a need for defusing include:

- loud, jumpy or rapid speech;
- rapid pacing;
- hitting or kicking of objects;
- squinting eyes or flared nostrils;
- arms crossed or on hips with fists clenched;
- lips pressed together or pulled back in a snarl.

The resident in need of defusing will almost always be standing. Past history of the resident will also be helpful in identifying signs that the resident is losing control.

Situations, which may require the use of defusing techniques, include:

a) A resident is highly argumentative with a staff member;
b) A resident is threatening a staff member;
c) A resident is threatening another client;
d) Two residents are arguing and are near fighting;
e) Staff are required to ask an upset resident to do something he may not want to do.

FYI - When a physical incident is already in progress, defusing procedures should not be used. At this point, physical intervention is necessary, which will be discussed later.

Steps in Defusing

The steps used in defusing a situation are the same as used in calming. The differences lie in how each step is carried out.

- Observation is the initial step done to determine the situation at hand.
- Preparation becomes more important because in these types of situations more than one staff member will be involved (see “Team Intervention Protocol”).
- The approach also becomes more important because it needs to be quick enough to be effective, but not so quick as to trigger further incident.
- Action differs from calming due to the fact that gaining control of the situation becomes your primary focus, and exploring the reasons for the behaviour becomes a secondary goal.

- Follow-up is similar in that it should have the long-term effect of calming the resident, but differs in the way that it is carried out.

1. Observation

Observation is extremely important when one or more agitated residents are involved. In certain instances, staff can have considerable control over when to intervene, and should take time to adequately observe and prepare before attempting to intervene. The interaction with the agitated resident or residents should be timed to be initiated when the conditions are most favourable to staff in terms of location of the resident, location of other residents, etc.

Important things to look for with a highly upset resident include:

a) The presence of weapons or potential weapons;
b) The presence of concealed weapons (i.e. bulges in pockets, etc.);
c) The presence of other staff who may be needed for assistance;
d) Escape routes if necessary.

On some occasions, there may not be enough time to adequately observe the situation before intervention is required. In these cases, observation should be done as you prepare and approach the client.

2. Preparation

In each situation that requires defusing, a few moments should be spent discussing who will do what. The guidelines for this are discussed in the “Team Intervention Protocol” section of this manual.

3. Approach

The highly upset or agitated resident should be approached calmly yet alertly. It is important to keep in mind that these residents require more personal space than a resident who is calm. Giving the residents ample room not only decreases the chance of the resident further escalating, but is safer for staff should the resident strike out. Also, it is important to never make the resident feel cornered, therefore no more than two staff should enter the room initially. If more staff are required they can enter the room when needed, until that time they should be immediately outside the door to the room.

If, during your observations, you notice a potential weapon that you are concerned about, try and stand between the resident and the weapon. As the intervention progresses, you may have an opportunity to inconspicuously move it or have other staff do so.

The stance, which should be used when attempting to defuse a situation, should be the same stance, which is described in the “Physical Intervention” section of this manual.

4. Action

a) **What to say and how to say it**

- Get the resident to say yes. It is hard to be angry when agreeing with someone.

- Also, get the resident to talk about anything. This is based on the assumption that talking and striking out are hard to perform simultaneously.
- You can get a resident to say yes by asking questions that you know require a "yes" response, and you can get a resident talking through the use of open questions.
- At this stage you are more interested in the fact that the resident is talking than in what the resident is saying;

b) **Remain calm**
- The tone of voice used in these situations should be neutral, neither friendly nor unfriendly.
- You must try to remain calm but firm. It is difficult for a resident to be angry with someone who is not angry in return.
- By using a tone of voice that is slightly slower and quieter than that of the resident, you provide a model, which will be hard for the client not to try and imitate.
- Residents at this stage of anger are often eager to focus the blame on others. Unless you are careful the resident will attempt to focus the blame on you and it will be difficult not to get angry in return.
- The best way to avoid this is to establish a relationship in which you can take the residents side as much as possible.
- You can agree with the resident on things such as his statement of the problem or the resident's feelings. By agreeing with the resident and allowing the resident an opportunity to agree with you, it is unlikely that the resident will continue to blame you.
- Once this part of defusing has been completed, the situation becomes more like one of calming, and the communication techniques discussed in that section can all be used;

c) **Use the light-to-heavy approach**
- Always order the techniques you choose to use from light (gentle persuasion) to heavy (strongly assertive).
- If you start off with a strongly assertive technique and it fails to work, it will be very difficult to then try a more easy-going technique and have it be effective.
- Be careful not to burn your bridges. An over-assertive technique can often trigger violence, and it is always easier to switch to a more assertive technique than to a less assertive technique.
- Switching to a less assertive technique can give the resident the idea that you are backing down;

d) **One resident**
- In many situations where just one resident is involved, you are making a request of him/her because of the resident's emotional state.
- Usually, the best way to do this is to state the request calmly and politely.

- If the resident refuses, listen to his arguments using active listening and paraphrasing, and then calmly but more firmly restate the request;

e) **Two residents**

- In situations where two clients are involved, the crucial first step is to break eye contact between them and separate them.
- Never step between two residents who are arguing.
- It is often possible to interrupt the argument by asking one of the resident involved (usually the one who is the least upset) to come over to you.
- At other times you will require two staff to intervene (one to talk with each resident).

FYI - Be careful not to humiliate, belittle, or challenge the resident while attempting to defuse the situation. This will only contribute to the resident's anger and escalate the situation further.

5. Follow up

As with calming, some type of follow-up is required with defusing. Inform other staff of the resident's concerns and how you addressed them. Document carefully. If you told the resident you would do something for him, do it as soon as possible. If the resident agreed to do something for you, check back in a reasonable amount of time to see if it has been done, and offer praise if the task has been completed.

Physical Intervention

During a difficult situation, despite attempts to de-escalate, physical intervention may be necessary. It is recommended that five people are needed for a physical intervention. Physical intervention should never be attempted without at least three people. If less than three people are present, keep yourself safe until help arrives.

In order for this to be done safely for both resident and staff, only two physical manoeuvres are recommended. These are the only two manoeuvres that should be needed in most situations, they are the Recommended Stance and the Escort manoeuvre. It is also important to remember that your approach to a resident when preparing for an intervention will have a strong bearing on the success of the intervention. The main part of this approach is using the proper stance.

Recommended Stance

The proper stance includes the following:

a) a forward trunk;
b) looking relaxed;
c) eye contact is important (not staring);
d) keep in mind personal space;
e) keep head turned toward resident
f) keep your feet shoulder width apart;
g) place equal weight on both feet;
h) keep knees slightly bent;
i) keep your hands waist to shoulder height (never clench fists).

This stance achieves three things:

a) helps to put resident at ease;
b) keeps you from falling in case of a sudden push;
c) provides readiness for a sudden change in resident behaviour.

Escort Manoeuvre

When needing to escort a non-compliant resident from one area to another, the following manoeuvre should be used; with one person on either side of the resident.

The escort will:

a) face resident, approach on an angle;
b) grasp resident 's wrists with inside hand;
c) pivot on inside foot, swinging around beside resident;
d) position outside arm comes around and under client's arm just above the elbow;
e) with outside arm around resident's arm, grasp your own wrist;
f) quickly turn your inside hand over, decreasing the chance of the resident breaking your grip.

Dealing with Physically Aggressive Behaviour

When confronted by someone who is angry or upset, there is always the possibility that the situation may escalate and the person may become physically aggressive. The following techniques will help you to protect yourself and others against this type of behaviour. The techniques are defence techniques only, designed to be easy to learn and use, and will cause no injury to the attacker.

Stance

When facing an individual who is angry or upset, always stand slightly sideways to protect the vulnerable middle areas of the body.

The arms can be held (but not folded) across the chest with one hand resting on the chin. This position (with the body slightly turned and the knees slightly bent) is fairly safe and appears relaxed and casual.

Never turn your back on an angry individual.

Control Position

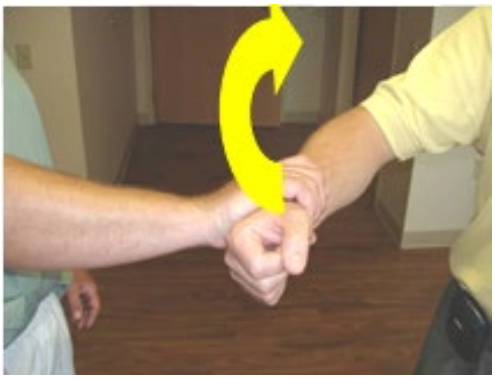
This is a temporary position and should be applied as quickly as possible. It should be used to momentarily maintain control of a person in order to allow someone else to get out of harm's way. The intervening staff member with the acting out person should always maintain control of one of the arms (do not let go of the wrist) and move his/her other hand under the acting out person's arm to gain control of the acting out person's loose arm.

- The intervening employee will take hold of the individual who is acting out by the wrists. The employee's left hand should take hold of the acting out person's left hand and the right hand should take hold of the right wrist, as shown in the first picture below.
- The employee's arm that is closest to the acting out individual should go UNDER the arm of the individual who is acting out, as shown is the second picture below.
- Once the employee has firmly grabbed the wrists of the acting out individual, slowly and in a controlled fashion, the employee could bend the individual over at the waste to take them off balance. This provides an opportunity for the employee to back away from the acting out individual.

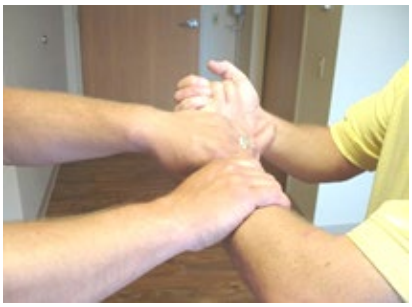
Grabbing Attacks

a) A one hand cross grab from the front is easily removed by rotating the grabbed arm to the attacker's side. Keep the grabbed arm bent and the thumb of the grabbed hand pointed upwards. If greater strength is required use two hands (clasped). If done correctly the attacker should end up turned away from you. If the attacker's hand is on top of your forearm, an alternative technique is to grab your own fist and pull your forearm towards your shoulder.

   This technique will also work if the attacker has both of your wrists. Simply rotate both arms to the outside. Alternatively, you can release your arms by keeping them bent moving them apart from each other in an irregular fashion, while moving away from the attacker with your back straight.



b) A two hand wrist grab is released by pulling your arm away from the weak link in the grip (between thumb and fingers). You can increase your leverage by using both hands.



c) A hand choke from the front can be removed by first clasping your hands in between the attacker's arms so that one of your elbows is above the attacker's arms and the other is below his arms. Then quickly exchange the positions of your arms, knocking the attacker's arms upward and downward.

d) A hand choke from the rear is removed by stepping forward and rotating to the left or right with that arm held high. Your shoulders should release the attacker's grip.

If you believe you will have trouble remembering which way to turn then raise both arms above your head and turn in either direction.

Once you have broken the hold remember to remove yourself from the situation as quickly as possible.

e) A hair grab from the rear can be released by grabbing the attacker's hand, cupping it, and pushing it tight against your head while rotating to face the attacker and stepping towards him.
f) A grab to long hair or clothing can be released by pressing your thumb into a pressure point located on the inner aspect of the arm, just above the elbow.
g) A rear choke with the arm is very dangerous, and perhaps the most difficult hold to release.

The first step is to pull the attacker's arm downward to decrease the pressure on the neck

Then rotate your neck towards the wrist of the choking arm, freeing at least one carotid artery from any pressure.

Next, convert the choke hold to a head lock by stepping to the side and blocking the attacker's heel with your inside foot. Once the hold has been converted to head lock, the danger is greatly reduced because the pressure on the front of the neck is relieved.

Escape from the head lock is achieved by quickly stepping backwards while tugging sharply downwards on the holding arm.

Striking Attacks

a) Punching attacks are generally to the head from a fair distance and to the body from close in. It is important to note that people tend to look at the area they intend to hit.

Most people will use a right handed round house punch. Always keep moving, holding your hands high.

Punches to the head are blocked by moving your arm between the attacker's fist and your head in an outwards motion away from your body.

Always try to block the attack using the muscle in your forearm and not the elbow or wrist.

Punches to the body are blocked by lowering the elbow and moving the hand in an outward motion towards your side. This will push the attackers hand away from you.

Again, try to block the attack using the muscle in your forearm and not the elbow or wrist.

b) Kicks are generally much slower than punches. Most often, they will be front kicks to the mid-section.

If you are standing close to the attacker, move in while twisting your hips to the side and raising your forward knee. This will block the kick with your shin on the attacker's ankle. If you are standing far away or don't see the kick coming in time, step backwards and rotate your hips to the side while knocking the attacker's leg with your forward hand.

Weapon Attacks

During a weapon attack, the main concern is for your own safety. If at all possible, run away. Do not try and be a hero and disarm the attacker. Call the police and let them handle the situation.

If you are facing the attacker, always start running backwards and then suddenly twist your hips and run forwards. The further you are away from the attacker when you turn the better. If it is not possible for you to run keep moving (either from side to side or in a circle), as it is harder to hit a moving target.

If being attacked by someone with a stick or a club held overhead, keep your head moving and try to get close to the attacker. The object of this is that you can block the arm rather than the weapon. If you need to block an overhead swing, keep your arm at an angle over your head so that hopefully the weapon will be deflected.

It is important to keep in mind that the striking distance is the length of the arm plus the length of the weapon.

Biting

When you are being bitten by an attacker the first reaction is to pull away, but this may result in tearing of flesh. Instead, push into the attacker's mouth, which will cause him to

have to open his mouth wider. Once you feel the pressure is released, then quickly pull away.