Handling violent or aggressive patients:
a plan for your hospital.

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HURDLES IN DEALING WITH VIOLENT OR AGGRESSIVE PATIENTS:

- Staff lack experience in dealing with such individuals.
- Hospitals lack “safe rooms” where a patient can be kept without danger to him or herself or others.
- Lack of adequate security personnel, esp. during evening and night hours.
- Distances to specialised units are far.
- Lack of clear referral paths to psychiatrists, who are not in oversupply.
A successful plan for preparing staff to deal with these cases involves:

- **Teaching staff how to anticipate when violent or aggressive behaviour may occur.**
- **Where in the casualty to place a potentially violent patient.**
- **When to request more assistance.**
- **Proper body language to employ.**
- **The preparation of a protocol for utilising emergency restraints either physical, mechanical or chemical.**
• Although aggressive behaviour can be a symptom of medical or psychiatric illness, most violent behaviour in our society is simple criminality, unrelated to illness, which is often better handled by the police, the prisons and the courts.

• However, deciding if such behaviour is the result of disease requires a medical and mental status evaluation.
• The vast majority of patients with psychiatric disease are never aggressive, dangerous or violent.

• Causes of aggressive and violent behaviour in casualty are many and include 4 broad categories:
  ➢ A. Psychiatric diseases.
  ➢ B. Organic brain syndromes.
  ➢ C. Drug and alcohol abuse.
  ➢ D. Personality or behavioural disorders.
A. Psychiatric diseases:

- **Acute Mania:**
  - A relatively common psychiatric cause.
  - Can be deceptive because the person may be outwardly quite pleasant and jovial---until angered!

- **Schizophrenia:**
  - Esp. the paranoid variety.
  - Often quoted as being a common cause of casualty department violence in the literature, but less common than mania.
B. Organic brain syndromes:

- By this term is meant confused and occasionally aggressive behaviour when the brain’s functioning is disturbed by:
  - Illness.
  - Head injury.
  - Disturbed metabolism.
- The hallmarks of this are:
  - Disorientation
  - A fluctuating level of consciousness.
  - Abnormal vital signs.
- More of a problem of the older, in-patient than the casualty dept. patient.
- Mental retardation / Dementia:
  - Diagnosis is usually well known to the caregivers and is often obvious to the medical personnel.
- **Metabolic causes:**
  - Diabetes Mellitus.
  - Dehydration
  - Renal impairment.
  - Hepatic impairment.
  - Electrolyte disturbances.

- **CVS causes:**
  - Anoxia.
  - CCF.
  - SBE.
  - Dissecting aneurysm.
  - MI.
  - Cardiac Tamponade.
• Infective causes:
  ➢ Meningitis.
  ➢ Viral infections.
  ➢ UTI's
  ➢ Syphilis.
  ➢ HIV-related.
  ➢ Malaria.
• Nutritional causes:
  ➢ Pellagra.
  ➢ Hypoglycaemia.
• Intracranial causes:
  ➢ Tumours.
  ➢ Haemorrhages.
  ➢ Epilepsy.
  ➢ CVA’s.
  ➢ Injuries.
- **Respiratory causes:**
  - TB.
  - Pneumonia.
  - Pneumothorax.
  - Pleural effusion.
- **Surgical causes:**
  - Paralytic ileus.
  - Acute abdomen.
  - Full bladder.
  - Sepsis.
  - Fractures.
- **Cause of post-operative and post-traumatic confusion is hardly ever psychiatric.**
C. Drug and alcohol abuse:

- Common cause.
- Alcohol:
  - Intoxication with or without Delirium.
  - Withdrawl Delirium (DT’s).
- Cannabis.
- Amphetamines.
- Cocaine.
- Benzene and glues.
- Methaqualone / Mandrax.
- Sedatives, hypnotics & anxiolytics.
- Anticholinergics.
- Steroids.
- Polypharmacy and overdosage: common in the elderly.
D. Personality or behavioural disorders:

- Those with antisocial, narcissistic or borderline personalities can be quite noisy and aggressive.
- These are usually not classified as having psychiatric illnesses.
- Difficult to handle because they cannot be “talked down”.
- More properly handled by hospital security or the police.
- “ACTING OUT” or Hysteria, esp. in adolescents—these can get quite aggressive.
When to be on the alert for the possibility of aggressive or violent behaviour:

- As in any problem, forewarned is forearmed.
- Important to know when aggressive or violent behaviour is likely to occur.
- Consider the following scenarios:
  - Family or friends use words such as “out of control”, “wild”, “crazy” or “angry” to describe the patient.
  - Patient is brought to the casualty restrained by friends, the police or the ambulance attendants.
  - Patient is under the influence of drugs or alcohol.
  - Patient has been known to have indulged in violent behaviour in the past, either towards others (e.g. spouse) or has behaved violently in the casualty.
• **High-risk factors associated with violence in the emergency department include:**
  - Alcohol or drug abuse.
  - Male gender.
  - Night time---possibly related to longer waiting times or to more prevalent alcohol and drug abuse during these times.
  - Past history of violence in Casualty Dept.
Who you should call for help:

- A. On call Medical Officer.
- B. Security staff.
- C. Police.
- D. Ambulance attendants.
- E. Hospital Manager.
A. On call Medical Officer:

- Needed for physical and mental state evaluation.
- Takes control of situation.
- Requires training in calming and restraint of patient.
B. Security staff:

- Also require training in calming and restraint of patients, especially in absence of police.
C. Police:

- Remember, most violent and aggressive behaviour is criminal in nature, and therefore should not be dealt with via the healthcare system.
- Call the police immediately if the patient:
  - Makes any threats, verbal or physical.
  - Acts destructively (e.g. hits the walls, destroys equipment, hits someone).
  - Is noisy, hyperactive and won’t quiet down after 1 or 2 requests.
  - Is armed (e.g. gun, knife or broken bottle.)
• Do not inform the patient that you have called the police—this may make him even more aggressive. “I’ll take them all on”.
• Do not try to negotiate with a person displaying this level of aggression.
• If after you have called the police, the patient seems to quiet down on his own, do not call off the police.
• Allow the police to come and evaluate the situation.
• The medical officer should evaluate whether it is safe to allow the police to leave.
D. Ambulance attendants:

- If the patient requires more security than can be offered by the nursing staff and security on duty, or if help is needed to apply or adjust restraints.
- Note: need to arrange an agreement with EMRS to provide this service.
E. Hospital Manager:

- If the police’s assistance has been summoned, need to inform the Hospital Manager.
Triage: where to place an aggressive or potentially violent patient:

- A. Patient already in restraints.
- B. Patient not in restraints, but high-risk.
- C. Low-risk patient.
A. Patient already in restraints:

- When the patient arrives already in restraints placed by the ambulance attendants or the police, move him into a “Crash Room”
- This should be the largest treatment room in the casualty dept.
- Large enough to accommodate several persons without crowding the patient.
- Large enough to allow staff to manoeuvre even when the patient is on a stretcher.
- This allows for any medical or monitoring equipment to be nearby, in case needed.
- Ask any accompanying relatives or friends to remain until a complete assessment has been done.
- Initially, do not remove the restraints—this may make the patient more aggressive.
B. Patient not in restraints, but high-risk:

- When the patient is not in restraints, but is noisy, on alcohol, big or “scary” and the MO is not immediately available, the nursing staff should ask the patient to wait in the waiting area in front of the nursing station.
- In this large, open area, the patient can easily be observed, has less access to hospital equipment, and it is more difficult for him to “sneak up” on staff.
- Try to keep the patient away from other waiting patients and from his friends or relatives---if you feel that they are worsening the situation.
- On arrival, the MO can decide whether to examine the patient in the “Crash Room” (high risk) or treatment room (low risk).
C. Low-risk patient:

- If you feel that the patient is low-risk (i.e. quiet on arrival, not on alcohol or is older), he may be taken to one of the examining rooms in the OP dept.
- Rooms that have exits at both ends are preferable so that no one feels trapped.
- Remove any sharp objects from the room beforehand.
- Leave at least one of the doors open, if possible.
How to act in the presence of aggression:

• A. Two’s company.
• B. Stay calm.
• C. Position yourself carefully.
• D. Body language.
• E. Offer a snack or drink.
• F. Check for weapons.
• G. Too hot to handle.
A. Two’s company:

- If you are frightened or made nervous by a patient, if possible, have another staff stay with you when you talk to him.
- You will feel calmer and more reassured and this will have a calming effect on the patient.
B. Stay calm:

- If the patient is angry and aggressive, speak slowly and politely.
- Try not to show anger yourself—this is difficult to do, but showing your anger only worsens the situation.
- Introduce yourself and ask why he is angry or simply ask him to tell you about himself—antisocial persons us. love to brag about themselves.
- Don’t argue back and don’t agree with the patient if he has any delusions or bizarre ideas.
- Allow the patient to “ventilate” a bit, without becoming judgmental—often, after a few minutes the patient does calm down.
• If the patient is simply angry, remember that sometimes he may have reasons for that anger: he may be in pain, may have waited hours in a crowded waiting room, may be stressed because of a sick spouse or child.

• Even a simple statement such as: “I know that you are angry about the 2 hour wait, but it’s hard for me if you are yelling. Why don’t you tell me what I can do for you, and I’ll try to help you out?” may help tremendously.

• Remember that a little empathy sometimes goes a long way!
C. Position yourself carefully:

- How far away from the patient should you stand?
- Stand about 1.5 metres in front of him, but a bit off to the side—do not face him directly.
- This is close enough to allow you to develop a rapport, but far enough away so that you do not threaten his personal space and he can’t easily touch or hit you.
- Don’t turn your back on him.
- Always approach the patient from the front.
D. Body language:

- Adopt a submissive pose: arms relaxed and hanging down at the side, palms open below your waist and facing the person, shoulders drooping, legs relaxed.
- Don’t look directly into the patient’s eyes because this is threatening to most people—focus your eyes on his chin.
- This is perceived as less threatening, and his hands can be easily seen.
E. Offer a snack or drink:

- Offer the patient juice, biscuits, a soft drink, and maybe have some yourself.
- Sharing food is a natural bond betw. people, and people aren’t as likely to argue if they are eating.
- If the patient is really insistent on a coffee, give it to him, but be aware that he can throw a hot drink at you.
- Sitting down together and talking or eating also forms a bond, but do not sit down if the patient refuses to sit down.
- Don’t sit in a corner, where you can be trapped.
F. Check for weapons:

• Check a purse or pockets for weapons, esp. if the patient is being admitted.
G. Too hot to handle:

- Although violence can occur quickly and randomly, in most cases there is some advance warning:
  - Anger.
  - Agitation.
  - A clenched-fists posture.
  - Loud behaviour.
  - Yelling.

- An important rule for nursing staff is that if the patient suddenly stands up and starts to yell or wags or points his finger at you, GET OUT OF THE WAY AS QUICKLY AS POSSIBLE!—this patient is too hot to handle.

- No heroics!---back out of the room quickly---run if you have to!
• If there are 2 of you on duty, run off in opposite directions—he can’t chase both!
• If you are really scared, lock yourself in a bathroom or run out of the building.
• Carrying a portable phone is a good idea—you can call for help.
• A violent patient is unlikely to hurt other patients---the staff is more at risk.
• If the patient runs out of the hospital---let him go.
• The MO can decide whether or not to call the police.
Use of restraints:

- A. Physical restraint.
- B. Mechanical restraint.
- C. Chemical restraint.

NOTE: The use of all types of restraints are for protective purposes, and NOT to be used as a punitive measure.
A. Physical restraint:

- Used for the purpose of either applying mechanical restraints or for the administration of sedation.
- The appropriate drug should be drawn up BEFOREHAND, while you assemble enough people.
- Approach the patient in a non-threatening manner, then overwhelm him quickly and efficiently.
- Each member must have a job—A grabs the right arm, B the left arm, C the right leg, D the left leg, E the head, while the 6th person either applies the mechanical restraints or administers the sedation.
- As soon as he is sedated, make a note of any injuries and examine carefully to exclude a treatable condition.
- Check that the patient is fully sedated before releasing the physical hold on him.
B. Mechanical restraints:

- If you are concerned for the safety of the patients or staff, it is permissible in an emergency to apply restraints prior to the arrival of the MO on duty.
- View the application of restraints as a procedure.
- Know when it is necessary and work according to a plan, with teamwork and a clear team leader.
- Inform the patient: “We are going to have to put you in restraints to help us protect you” (or, “to protect ourselves”).
- If the patient appears to consent, fine, but once you’ve decided to apply restraints, don’t discuss or negotiate further.
- Apply the restraints as quickly and humanely as possible.
- Even if the patient calms down, the nurses should not remove them.
• The MO should decide when it is safe to remove the restraints.
• It may be safer to leave the patient in a lateral position because aspiration may occur.
• A soft neck collar may also protect the patient and it makes it more difficult for him to bite someone.
• Obtain a written medical order for the restraints as soon as possible.
• Don’t leave a restrained patient alone in the room.
• Make sure there is some kind of monitoring regimen in place.
• Watch the patient’s head --- he can still bite!
• Restraints should be removed after every 30 minutes, after patient has been sedated.
• These restraints should be padded leather straps.
C. Chemical restraint:

- Drug Therapy has to be part of the overall plan.
- No sedative is ideal for all situations.
- Know a few well, including side effects and precautions.
- Drugs used to control agitation take time to work, therefore give earlier rather than later.
- Drugs commonly used:
  - Lorazepam (Ativan).
  - Haloperidol (Serenace).
  - Clothiapine (Etomine).
  - Zuclopenthixol acetate (Clopixol Acuphase).
  - Chlorpromazine (Largactil).
  - Olanzapine (Zyprexa).
• Before administering sedation IM or IV, offer oral medication such as Chlorpromazine (Largactil) at a dose of 50mg to 100mg p.o. stat, unless contraindicated.

• Resort to IM or IV sedation ONLY if:
  ➢ Patient is potentially a danger to self and/or others.
  ➢ Patient refuses oral medication.
  ➢ Patient requires rapid control of behaviour.

• Following administration of sedation, it is imperative to monitor vital signs as often and regular as possible, e.g. every 15 minutes for 4 hours and then taper as necessary.
Lorazepam (Ativan.):

- Not as effective if given orally.
- 2mg to 4 mg IM or IV slowly.
- Max. 6mg in 24 hours.
- Good choice in patients with:
  - Suspected drug-induced disorder.
  - “Organic brain syndrome”
  - Mania.
- Efficacy enhanced by co-administration with Haloperidol IM or IV.
- Adverse effect: watch for respiratory depression, hypotension and behavioural disinhibition, esp. in the elderly.
Haloperidol (Serenace.):

- 5mg IM or IV.
- Can repeat within 1 to 2 hours.
- Max. 3 doses in 24 hours.
- Use half doses in the elderly.
- Relatively safe, effective and cheap.
- Adverse effects:
  - Some EPS reactions: dystonias, akathisia, motor restlessness.
  - Rarely:
    - Sudden death.
    - Neuroleptic Malignant Syndrome.
- Rx:
  - Administer Biperiden (Akineton) 5 mg IM; change to an “atypical” or decrease dose.
**Clothiapine (Etomine.):**

- 120mg to 160mg/day po, IM or IV in 2 to 3 divided doses initially.
- Max. 360mg/day.
- **Adverse effects:**
  - Sedation.
  - Orthostatic hypotension.
  - Arrhythmias.
  - Epileptogenic.
  - Tissue necrosis.
  - Arterial thrombosis with gangrene.
Zuclopenthixol acetate (Clopixol Acuphase.):

- 50mg to 150mg IM, may be repeated, if necessary, after 2 to 3 days.
- Very effective in belligerent and aggressive patients with no response to earlier measures.
- Use only if no response to Lorazepam and / or Haloperidol.
- Use with caution:
  - Recent excessive use of alcohol.
  - Dehydration.
  - Electrolyte imbalance.
- Adverse effects:
  - Sedation which lasts for days.
  - Hypotension and circulatory collapse.
Chlorpromazine (Largactil.):

- 50mg to 100mg po stat or 25mg to 50mg IM.
- Adverse effects:
  - Very sedating.
  - Hypotension.
  - Painful injection.
- Contraindications:
  - Epilepsy.
  - Recent excessive use of alcohol.
  - Chronic hepatic disease.
  - Elderly.
  - Recent history or evidence of head injury.
  - Pre-existing cardiac disease.
Olanzapine (Zyprexa):

- 10mg IM stat.
- May have specific anti-mania effect.
- 10mg roughly = 7.5 mg Haloperidol.
- Virtually no EPS.
- Occasional hypotension.
- Little sedating effect, therefore advantage in elderly.
- Patient remains alert, oriented and cooperative.
- Has delayed onset of action, may take days.
- Very expensive.
Points to note:

- The time to make your hospital plan is now at 1100 AM, NOT at 0300AM when someone is tearing up your casualty dept.
- Specify where to put the patient, who to inform, rules for restraints, etc.
- Train your staff.
- Go over the plan with them. Why not hold a practice session? With a simulated “patient” on how to handle an “agitated patient.”
- Build a hospital “secure room”
- Have a contract with a security firm.
- Understand the role of your local police and ambulance attendants.
Summary:

- Be sure your hospital has a proper plan for handling the violent or aggressive patient.
- This plan should specify:
  - Resources available
  - Who should be called
  - Where to put the patient
- Train your staff in proper procedure and body language for dealing with this difficult clientele.
- Debrief your staff after an incident.
- Discuss how the situation went, what was done well and what could be improved on the next time.
THANK YOU

For your attention............