Patient Safety Tip of the Week

March 19, 2013

Dealing with the Violent Patient in the Emergency Department

Over the last decade we have seen increasing numbers of violent incidents against healthcare workers. Hardly a week goes by now that we don't hear about a healthcare worker somewhere being injured by a patient. Joint Commission in 2010 issued a Sentinel Event Alert "Preventing Violence in the Health Care Setting", drawing attention to the various risk factors and making recommendations that organizations should implement to reduce the chance of harm to healthcare workers, patients or visitors. Workplace violence in healthcare settings obviously involves much more that patients directing violence toward healthcare workers. But today's column deals just with the violent patient.

Among health care workers, 46% of all nonfatal assaults and violent acts requiring days away from work were committed against registered nurses (Bureau of Labor Statistics 2009). About 40% of psychiatrists are assaulted by patients at some time in their careers (Tishler 2013). But note that there is probably general underreporting of violence against healthcare workers.

Historically, the emergency department has usually been the area impacted by violence the most. 25% of ED nurses responding to a survey reported experiencing physical violence more than 20 times in the previous 3 years, and almost 20% reported experiencing verbal abuse more than 200 times during the same period (Boyett 2009). But we've also seen an increase in violent acts committed against staff in behavioral health units. The recent epidemic use of "bath salts" seems to have played a role in the increased violence in both areas. More and more we are seeing agitated, disoriented patients being brought to emergency departments by ambulance or by police. Long waits in the ED often lead to escalation of agitation and anger and violent behavior.

An article in the March issue of General Hospital Psychiatry (Tishler 2013) has an excellent and timely update on the assessment and management of the violent patient in critical hospital settings. Though it focuses on mental health care professionals working in the emergency department, it really applies to all health care workers in the emergency

department or other hospital settings. This builds upon previous work by one of the authors (Tishler 2000). In addition to long ED waits, Tishler and colleagues note that overcrowding, small spaces, alcohol and drug reactions, the loud and chaotic ED environment and lack of an established therapeutic relationship are contributory factors. They also note that sometimes partners who accompany the patients may be unhelpful and actually serve to escalate situations. Lack of access to history and patient inability to provide accurate information are also problems.

The key to avoiding injuries due to violence in the ED is recognizing patient risk factors for violence, identifying circumstances or context that make violence more likely, and then recognizing signs of escalation.

Newton and colleagues (Newton 2012) had found 9 **risk factors** predicted 80% of violence in psychiatric inpatients. These were:

- diagnosis of psychotic disorder or bipolar disorder
- age younger than 35 years
- male gender
- below-average estimated intelligence
- psychiatric history
- no history of employment
- homelessness
- aggressive or agitated behavior

Notably absent from the Newton study were risk factors related to alcohol or substance abuse. However, the authors suspect that may reflect unavailability of information about those risk factors at the time of admission.

Tishler et al (Tishler 2013) discuss potential **antecedents to violence** and note that acute substance abuse or use of alcohol are very common. Stimulant drugs (cocaine, crack, amphetamines, and phencylclidine) are particularly likely to antecede violent behavior (as above, we'd add "bath salts" to that list). They note common clues of methamphetamine use are infections at injection sites, tooth decay, a gaunt appearance, and odor of ammonia.

They also note other common antecedent events are divorce, death of a loved one, financial problems, recent trouble with the law, child custody battles, or recent elopement from a psychiatric facility.

But they also describe occurrences in the ED that may trigger violent reactions. These include staff-patient interactions perceived as threatening to the patient, excessive sensory overload (lights, noise, people, etc.), and discussing treatment plans or security worries outside the patient's room where they might be overheard by the patient.

Warning signs noted by Tishler et al. include:

- Loud speech
- Profanity, overly sexual content, intimidating language

- Demanding unnecessary care
- Accusing clinicians of conspiring
- Throwing or punching inanimate objects
- Rapid pacing
- Darting eye movements
- Clenched jaw
- Clenched fists
- Invading one's space
- Inability to comply with directions or reasonable limit setting

The Tishler paper really emphasizes that clinicians need to have a "repertoire" of potential interventions to deal with such patients once they recognize the risk factors and warning signs. That way, if one strategy fails to de-escalate the situation they can try others. The patient should be separated from others to prevent unnecessary stimulation. Obviously access to potential weapons should be minimized. The presence of another ED staff member (or other responsible adult) may help while the assessment is ongoing but they caution that the presence of security personnel in the treatment room may serve to escalate the situation. They go on to discuss verbal de-escalation techniques and environmental ones. For example, if the patient is perceived to be claustrophobic, moving to a larger room may be beneficial.

Physical restraint of patients once violence is imminent is beyond the scope of our column. Most hospitals that have behavioral health units train staff in de-escalating techniques and in the proper manner to apply physical restraints. That training includes not only behavioral health personnel but also ED personnel and anyone who might be called upon to respond to violent patient situations. However, we're not sure how well trained the ED staff (and other staff) are at non-psychiatric hospitals. We suggest that if you are not a psychiatric hospital you consult with your state or regional mental health agency to find out how to get such training for your staff. The last thing you want is one of your staff members getting disciplined by a regulatory agency for responding to a violent situation but using the wrong techniques.

The Tishler paper has an excellent discussion about the pharmacological management of the acutely violent patient. This includes not only choice of the various types of medications but also routes of administration, side effects, and other adverse effects. Keep in mind that some of the antipsychotics potentially used may prolong the QT interval and predispose the patient to ventricular arrhythmias like torsade de pointes (see our Patient Safety Tips of the Week for June 29, 2010 "Torsade de Pointes: Are Your Patients at Risk?" and February 5, 2013 "Antidepressants and QT Interval Prolongation"). We will also echo their warning about the potential for respiratory depression when benzodiazepines are used.

The Tishler paper is a very timely and practical update on managing the violent patient in the emergency department or other settings.

There are a number of excellent resources available regarding violence in the hospital. The 2010 Joint Commission Sentinel Event Alert had many useful recommendations. Around the same time ECRI Institute (ECRI 2011) put together a tool for screening your facility for factors important in patient violence and other workplace violence. OSHA has extensive guidelines for preventing workplace violence for health care and social service workers (OSHA 2015). The American College of Emergency Physicians has a position statement on preventing emergency department violence (ACEP 2011). Lastly, the Emergency Nurses Association (ENA) has an outstanding toolkit and resources for dealing with workplace violence. These include ED risk assessment tools, templates for actions plans, and a variety of other great resources.

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