How to deal with violent and aggressive patients in acute medical settings

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Abstract

Dealing with violence and aggression is an area where health professionals often feel uncertain. Standing at the interface between medicine, psychiatry and law, the best actions may not be clear, and guidelines neither consistently applicable nor explicit. An aggressive, violent or abusive patient may be behaving anti-socially or criminally. But in acute medical settings it is more likely that a medical, mental health or emotional problem, or some combination thereof, is the explanation and usually we will not know the relative contribution of each element. We must assume that difficult behaviour represents the communication of distress or unmet need. We can prevent and de-escalate situations by understanding why they have arisen, identifying the need, and trying to anticipate or meet it. In these situations 'challenging behaviour' is much like any other presenting problem: the medical approach is to diagnose and treat, while trying to maintain safety and function. In addition, the person-centred approach of trying to understand and address psychological and emotional distress is required. Skilled communication, non-confrontation, relationship-building and negotiation represent the best way to manage situations and avoid harm. If an incident is becoming dangerous, doctors need to know how to act to defuse the situation, or make it safe. Doctors must know about de-escalation and non-drug approaches, but also be confident about when physical restraint and drug treatment are necessary, and how to go about using appropriate drugs, doses, monitoring and aftercare. There are necessary safeguards around using these approaches, from the perspectives of physical health, mental wellbeing, and human rights.

Keywords: acute hospitals, challenging behaviour, de-escalation, distress, rapid tranquilisation, violence

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Introduction

Violence is the use of physical force, verbal abuse, threat or intimidation, which can result in harm, hurt or injury to another person. Aggression is a hostile behaviour or threat of attack. Both are part of a larger group of challenging behaviours: non-verbal, verbal or physical actions which make it difficult to deliver good care safely.[1,2]

Unfortunately, aggression in acute hospital settings is common, especially low-level resistance, hitting out or other physical assault, or verbal abuse. Many healthcare professionals, especially nurses, feel it is part of the job, and simply tolerate it. But it can result in serious injury to the patient, staff, other patients or visitors, and contributes to staff stress and work absence.[3]

Interpreting aggression and violence is complex and can be misunderstood. Politicians and the press often assume it has a moral basis; aggression is due to lack of control or respect, or is associated with intoxication with drugs or alcohol. Sometimes this is the case; intentional or wilful aggression or negligent harm committed by someone with mental capacity is a crime. But there are other possibilities. For doctors and other staff in acute medical settings there is uncertainty, about why it is happening, or what you can do to stop it. Healthcare staff are called upon to make decisions about how to respond, including whether to involve psychiatrists, security staff, or the police, or using physical restraint or medication to try to reduce the behaviour or regain control. Decisions must be made on the basis of limited information, often in a hurry. This can result in unease, indecision and stress.

In general hospital settings, aggression is commonly assumed to be most prevalent in Emergency Departments, where dealing with aggression is a significant concern. But NHS incident reports indicate that events are numerically more common on medical, geriatric and psychiatric wards.[4] The most likely demographic involved in incidents is men aged between 75–95, with their female peers not far behind (Figure 1), strongly suggesting that delirium and dementia lie

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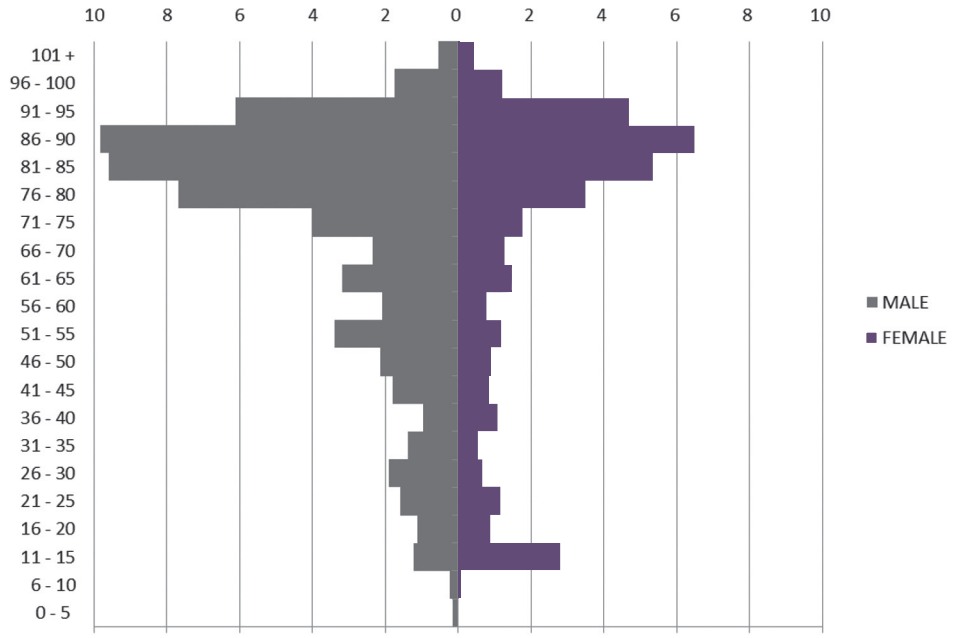

Figure 1 Population pyramid for occurrence of violent incidents in acute hospitals by age range and gender of alleged perpetrator (2010–2015). Source NHS Protect[4]

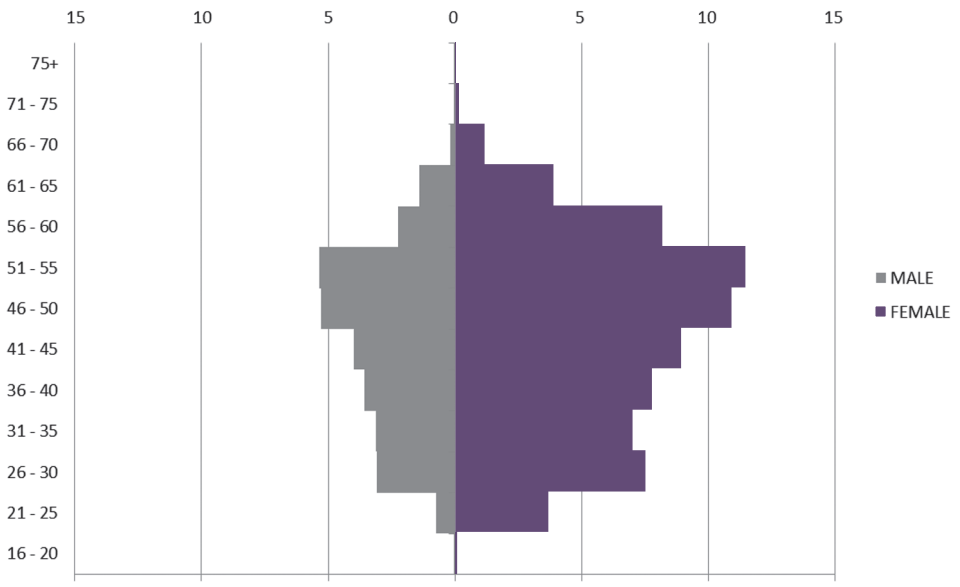

Figure 2 Population pyramid for occurrence of violent incidents in acute hospitals by age range and gender of victim (2010–2015). Source NHS Protect[4]

behind much of the problem. Female nurses are most often the victims (Figure 2). These data take no account of cause, severity or likely under-reporting.

Understanding challenging behaviours

There is always a cause for aggression. The cause will be a combination of factors intrinsic to the patient, such as personality, physical symptoms or intense mental distress, and extrinsic factors, including attitudes and behaviours shown by staff and other people, the physical environment, and restrictions that limit the patient's movement or actions.[1]

A good starting point is to assume that any aggression indicates a patient's distress, or an attempt to communicate unmet needs, in someone whose coping abilities have been exceeded. The person wants something, wants to do something or is afraid of something. Prevention means understanding the reasons for distress, then anticipating and meeting needs. Dealing with violent situations when they occur is a last report.

Since the 1990s the NHS has had a policy of zero-tolerance to violence against staff. This calls for setting and communicating explicit boundaries of acceptable behaviour, warning or confrontation if they are breached, followed by resorting to coercive enforcement (security staff or the police), and possible exclusion from services or judicial sanction if transgression is serious or repeated. The underlying assumption is that acts of aggression are, or should be, under voluntary control. If they are, individual patients should exercise that control, and violence is a crime. But in practice determining degrees of control and culpability are not so simple. Conditions associated with aggression include delirium, dementia, psychosis, intellectual (learning) disability, personality disorder, grief, anxiety, frustration, and

Table 1 Mental state examination

Domain	Comments
Appearance and behaviour	Describe what you see objectively and dispassionately. Alertness, vigilance, attentiveness or distraction, motor activity, involuntary movements, calling out, mood, emotions, response to interaction and care giving, evidence of reaction to delusions or hallucinations
Communication	Assess and record understanding and expression, as in a neurological examination, and content of speech. Note sensory impairments
Mood and emotions	Ask about mood. Consider elation, enjoyment, hopelessness, guilt, self-harm or suicidal ideation. Biological features of depression, including sleep and appetite. Emotions such as anxiety, fear or anger
Perceptions	Hallucinations are perceptions not explained by sensory stimulation – visions, voices, sometimes other modalities
Thoughts	Delusions are strongly held false beliefs, not culturally or religiously appropriate. Often paranoid (involving threat of harm), but may be grandiose, or nihilistic ('mood congruent'). Ask about worries, or if the person is being treated well by others
Cognition	Orientation, memory, attention (days of week or months or year backwards), reasoning and logical thought; use a brief screen such as the Abbreviated Mental Test score, and a delirium screen such as 4AT or Confusion Assessment Method.
Insight	To what extent does the patient realise there is a problem?
Risk	Of harm to self or others, suicide, absconding, self-neglect, exploitation
Mental capacity	Ability to make a specific decision, for example about remaining in hospital or receiving medical tests or treatments

unpleasant symptoms. In an acute medical setting most instances of aggression will not be culpable. In this context an approach advocating 'zero tolerance' is insufficient. It may be that under sufficiently extreme circumstances and provocation any of us could become aggressive.

Some groups of patients represent a higher risk than others, including those with cognitive or mental health problems, drug or alcohol misuse, or a history of crime or aggression, but together these comprise a large proportion of service users.[5,6] On an acute medical admissions unit, staff are confronted with problems or crises, which must be diagnosed and managed effectively and safely, often without full knowledge of background information, nor, at the point of assessment, the contribution of medical, mental health or social causes. Medical admissions units will always be areas of high risk.[4]

Physical causes for aggression include unpleasant symptoms; for example pain, delirium, sleep deprivation, drugs or alcohol, communication problems, visual or hearing impairment, or needing the toilet. Cognitive factors include forgetfulness and disorientation, causing someone to think they are in a time or place they are not, inability to understand what is being asked of them or to say what they want, disinhibition, or poor insight. Mental health problems include paranoid delusions or hallucinations; thinking others are trying to harm you, seeing a threatening vision or hearing a voice telling you to harm yourself or others is a powerful motivation to act aggressively. Emotions such as fear, anxiety, grief, frustration or anger are commonly experienced in the context of ill-health of individuals or those close to them, or bereavement. Much about the hospital environment provokes problems; hospitals are noisy, busy, crowded, unfamiliar places, overwhelming and overstimulating, and patients or relatives may feel they lack control over events. Hospitals can also be boring, with long periods of inactivity, long waits, lack of information, or restricted movement, and little access to fresh air (or cigarettes). Hospitals concentrate people who are vulnerable, who cannot understand, cannot communicate, who misinterpret, or who have a different perception of reality or different priorities. Provocation though illness, environment or relationship problems with staff or the organisation may lead to strong emotions, and personality or cognitive limitations may make these difficult to control.

Prevention

Prevention is skilled and needs good leadership, which sets priorities, role-models best practice, validates or complements good practice and challenges poor practice.

Individual professionals working within a complex system are unlikely to have much direct control over the environment, especially areas such as the Emergency Department or acute admissions areas, nor over staffing or processes. But when systems are redesigned or refurbished the impact on the behaviour of vulnerable service users should be taken into account, in the same way that children's emergency services strive to make the experience more approachable and less threatening for those who use them.

Individual professionals should try to ensure that what they do have control of minimises the chances of upset, conflict or aggression; in the way we behave, communicate and think about the problems with which we are presented. We can try to minimise noise. We can make the encounters that we have as empathetic and sympathetic as possible. Prevention requires a culture that is non-judgemental, promotes

collaboration between staff and patients, and adapts care to the individual. Prevention needs good communication, and relationship-building based on meeting physical, psychological and emotional needs.[2,7,8]

As physicians, our first job is to get the medicine right. We must diagnose systematically and thoroughly, including functional and social aspects, seek out delirium and symptoms that may be hidden, especially pain or psychosis, and prescribe (or de-prescribe) carefully.

We need skill in assessing the mental state and cognition. This is something a physician can learn, albeit unfamiliar to some. Increasingly acute medical services are supported by liaison psychiatry, and other professionals such as psychiatrists or mental health nurses may be available to help. Mental state examination is a process of observation and questioning (Table 1). Observe alertness, arousal and attention (key abnormalities in delirium or intoxication, but also neurological disease or trauma). Assess understanding and expressive communication; you cannot communicate well if you do not know your conversation partner's ability. Ask about mood and emotion: anger, anxiety and fear. People will not tell you about their delusions or hallucinations unless you ask them sensitively. You can consider insight, risk and mental capacity at the same time.

Good communication is central to establishing a relationship with the patient and averting or defusing distress. Introduce yourself; be polite, friendly and respectful. Say who you are and what you are doing. You might start with a few words of general conversation to create rapport. Keep language simple and check understanding. Be calm and use non-threatening tone, body language and content; talk to the patient at the same physical level, show concern, smile. If you are doing something, for example an examination or a procedure, give a running commentary on what you are doing to allay misunderstanding or fear. This is especially important for nurses giving personal or intimate care. Do not contradict, confront, embarrass or humiliate, even when the person is disorientated and mistaken. There is skill to 'validating' what someone says without deceiving, infantilising or condescending.[7]

Families will mostly be useful allies. Welcome and engage them. They have information you need; you have information they need. They may or may not want to help with sitting, activity or hands-on care. You will need them for decision-making and discharge planning if the person is dependent on them or lacking in mental capacity to decide. If someone is prone to agitation or aggression family members may be able to explain why, what normally provokes or calms the situation, and may help the patient by being a familiar and reassuring presence.[9]

Escalating situations

If a situation gets more difficult, you need to 'de-escalate' it. This is sometimes referred to as 'non-pharmacological' or 'behavioural' strategies, but often it is not clear what this means. In mental health practice it may be called 'talking down'. It is multi-professional – nurses or therapists may help – but doctors must know what to do and what their specific role is. The goal is to get the patient to a less distressed and more trusting state.

If possible (and safe) try to remove the provocation (even if you are not sure what is provoking) by leaving the patient alone for a while, (a 'leave and return' strategy) giving them some physical and emotional space. If not, or when things have settled a bit, stay calm and friendly, and ask what you can do to help? What concessions can you make to what the patient wants? If there are immediate needs such as for pain relief or the toilet try to provide them. If oxygen, urinary catheters or intravenous lines, or noise, are irritating, remove them if you can. Acknowledge the distress without making accusations; for example 'you are obviously upset' or 'you seem very angry'. Threats or getting angry yourself never helps, and are likely to make matters worse. This is sometimes called 'emotional and behavioural self-regulation'; ensuring that we respond to anger or conflict in a calm and measured way, trying to promote collaboration and avoid further provocation. This is not easy if you are being threatened or attacked, and is helped by access to a source of practical and emotional support for staff. On the other hand, 'how can I help?' is very disarming. Asking the patient how to defuse the situation can also help (called 'positive engagement' in mental health practice).

By engaging in a potentially difficult situation you are taking a risk. If at this point you get hit, you may look naïve. Judgement is very important; colleagues, including nurses, may help to talk through balancing the risks. All staff should be trained in 'breakaway' techniques (how to free yourself from a patient who tries to hold you) just in case. Ensure your escape route is clear in case you have to withdraw quickly, and support is at hand if risk is high, from security staff if necessary, preferably out of sight. If in doubt, choose the action you think is safest.

Most hospitals have adult mental health, old age and learning disability liaison psychiatry teams. If needed, they may be able to attend crisis situations immediately. Call security staff if risk persists or you cannot control the situation, especially if weapons are involved. Call the police if you think a crime has been committed or security staff advise it.

Medication may help in the de-escalation process. If someone is withdrawing from alcohol, is clearly in pain, or psychotic, try to get the person to take appropriate oral medication. Drugs should be targeted at a symptom; as a general rule, antipsychotic drugs are preferred to benzodiazepines, especially in psychosis, mania and delirium. Benzodiazepines are better in alcohol withdrawal, post-ictal epilepsy, Parkinson's disease and Dementia with Lewy Bodies. Aim for therapeutic intent (treat an identified problem) rather simply aiming for sedation.

Table 2 Rapid tranquilisation. Offer oral medication first. The drugs in the table are given intramuscularly, following safe physical restraint, with doses at 20–30 min intervals until adequate effect is achieved or maximum dose is reached

Patient group	Try first	Try second	Maximum dose in first 24h[+]
Highly aroused, physically robust adult, including those already on antipsychotic drugs	Lorazepam 2 mg	Repeat, then try haloperidol 5 mg[*]	Lorazepam 4 mg Haloperidol 12 mg[++]
Alcohol withdrawal	Lorazepam 2 mg	Repeat	Lorazepam 8 mg
Frail older people or severe respiratory disease	Haloperidol 2.5 mg	Lorazepam 0.5–1mg	Haloperidol 10 mg Lorazepam 4 mg
Dementia with Lewy bodies, Parkinson's disease	Lorazepam 0.5–1 mg	Repeat	Lorazepam 4 mg
Delirium	Haloperidol 2.5 mg	Repeat	Haloperidol 12 mg[++]

*NICE guidance recommends combining haloperidol with intramuscular promethazine 25–50 mg; maximum 100 mg in 24 h; the evidence for this is quite weak and the injection is painful

[+]British National Formulary maximums should only be exceeded if clinically necessary, and after review by a senior doctor. If control is not achieved with maximum doses consult a senior doctor. Consider intravenous midazolam 1–2 mg boluses at 2 min intervals, maximum 20mhg. Move to critical care

[++]The Summary of Product Characteristics for intramuscular haloperidol gives a maximum of 18 mg/d. The British National Formulary recommends a maximum of 12 mg/d. At the time of writing the discrepancy has not been resolved.

Managing crises

If a violent incident is imminent or has occurred, you need to intervene. The criterion to act is that there is an immediate grave risk of serious harm to the patient, other patients, visitors or staff. Destruction of property or the care environment may be another indication. These are judgement calls, which can be shared with medical or nursing colleagues if they are available. The aim is to take action to end the incident, ensure safety for all involved in the incident or in the vicinity, and to minimise physical and psychological harm to the patient who is being aggressive.[1]

Crowds can exacerbate the sense of threat, so clear the scene of other people. One person should take charge, with one or two colleagues or security staff in support. Family members may or may not be able or willing to help, and you may or may not wish to ask them to leave as well. Exactly what you do will depend on the situation. Bear in mind that the patient may have urgent medical needs (ask yourself how you would know if this person had hypoglycaemia or meningitis). Immediate physical separation may be needed if a patient is holding another patient, a staff member or visitor. Otherwise, physical restraint of the patient may be required to prevent injury or harm, or to enable the giving of parenteral medication or other medical treatment.

De-escalation should be continued all the time, talking, reassuring, negotiating, trying to make compromises. However, physical intervention should be undertaken quickly and efficiently once a decision has been made that it is needed. Physical restraint should ideally only be done by those specifically trained in it, and unfortunately very few staff in general hospitals are. Security staff should be, as are mental health nurses, and some staff in Emergency Departments. The senior nurse on the scene should know (or ask around). If the situation is sufficiently urgent, such as contact aggression, you will have to make a judgement on what you can safely manage given your own body size, strength and state of health. Two staff, working from behind lifting by the shoulders using a 'scoop and go' method usually works in separation if one patient is in contact with another. Attention should also be paid to the person who was attacked, to avoid retaliation against the aggressor. Physical restraint should be the minimum necessary for the shortest period of time. Restraint is best done seated on a bed or kneeling. Try to avoid taking the patient to the ground, but if this is not possible, protect the head from injury, and try to restrain supine not prone. Ensure the airway is not obstructed or ventilation prevented by chest restriction; monitor oxygen saturations regularly.

Usually physical restraint will be accompanied by rapid tranquilisation with drugs. You need control quickly, within 30–60 minutes. The aim here is sedation. This means giving enough drug to get a rapid effect, but not so much to cause harm. Each dose takes 20–30 minutes to reach peak effect, so wait between doses. Monitor vital signs continuously if necessary. Keep flumazenil available for respiratory depression with benzodiazepines, and procyclidine for dystonic reactions to haloperidol. Review drugs for effect and adverse effect, as much as hourly.

Table 2 gives some suggested rapid tranquilisation guidelines. Use 'small doses for small people', especially frail older people and those with respiratory disease. Those withdrawing from alcohol or already on antipsychotic drugs will require larger doses or different drugs. Try not to exceed the maximum doses allowed in 24 hours, unless sanctioned by a senior doctor. NICE guidance on rapid tranquilisation suggests using lorazepam as the first-line drug in mental health and emergency department settings, due to concerns that haloperidol has potential for causing arrhythmias and

extrapyramidal side-effects. However, these are rare if use is for a short duration, in an emergency situation. The empirical evidence behind the exact choice of drugs is poor; there is little to suggest any difference in efficacy or safety. NICE suggests that if haloperidol is used, promethazine should be added to enhance the sedative effect and reduce the chances of side-effects (presumably because promethazine is quite anti-cholingeric, which makes it best avoided in people with delirium and dementia).[1] However, the evidence for adding promethazine to haloperidol is quite weak. Benzodiazepines are best avoided in patients with delirium (other than that due to alcohol or benzodiazepine withdrawal, or complicating Dementia with Lewy Bodies or Parkinson's disease), frail older people and people with respiratory disease.

Healthcare professionals are often unsure about what is legally permissible. Details vary by jurisdiction, but the principles behind English, Scottish and international law are the same. Mostly in these situations we will assume lack of capacity, but you must try to test it explicitly if there is doubt, which is difficult in a crisis situation. You can treat without consent to preserve life or health in an emergency. Restraint (physical, pharmacological or environmental) is allowed so long as it is necessary and proportionate to the risk of harm, and is the least restrictive alternative. Those lacking mental capacity may be treated if it is their best interests, and if no legal proxy (such as a Lasting Power of Attorney) has been appointed. Best interests should be assessed, taking account of individual preferences wishes and values, and consulting the patient family and others close to the patient if they are available and there is time. But this should not prevent giving medical treatment, including rapid tranquilisation, when it is immediately necessary. You may need to call a psychiatrist to consider detention and treatment under the Mental Health Act if the person is mentally ill and a danger to themselves or others. The duty of care for the provision of medical care remains. Employers will also have responsibilities to the patient, other patients, visitors and staff under health and safety law.[2] In general, the courts and professional regulators are supportive of professionals who act in good faith in difficult and dangerous situations.

Documentation is important; these situations can be contentious, especially if something goes wrong. Record your rationale, and what non-pharmacological de-escalation measures were used. Ideally a formal staff debrief should follow an incident: if not, talk it through with colleagues, or present the case at a clinical meeting or Schwartz Round.

Practicalities and pragmatics on an acute medical unit

The acute medical unit is a transient setting, designed to deliver safe and efficient diagnosis and initial management of primarily medical problems. But we cannot avoid comorbid cognitive or mental health disorders, and we should try to mitigate the effects of impersonal systems and provocative environments if we can. Upset is a harm, and delivering safe care means we must strive to minimise all kinds of harm.

The intensity of work, the need for rapid decision making and action in an emergency, and lack of continuity means that compromise and judgements are necessary. Treat each situation on its merits, and try to learn from experience. A formal risk assessment around managing violence and aggression should be undertaken by service and clinical managers.

Mental health practice and NICE guidance asks for advance care planning involving the patient where occurrences of physical restraint or rapid tranquilisation are likely or recurrent, and both internal and external review of incidents. None of this is likely to be possible on an acute medical unit. The advice to use haloperidol only after an electrocardiogram has been done also seems optimistic in situations requiring rapid tranquilisation to rescue a crisis situation.

Despite the challenges, we should strive to find a way to give priority to emotional and psychological support to patients alongside task-based medical care. In general, physicians do this remarkably well. We do the best we can, informed by multiple competing needs and priorities.

The approach I have described will help for people who are aggressive due to physical, mental or situational factors, but also people who are drunk, bereaved, angry after waiting, or with difficult personality traits or personality disorders.

Acknowledgement

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