



Managing Assaultive Behavior for Healthcare Professionals

Three (3.0) Contact Hours

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Purpose

The purpose of this course is to provide healthcare professionals with information that will assist with learning how to manage assaultive behavior in the workplace.

Learning Objectives

After successful completion of this course, you will be able to:

1. Identify characteristics associated with aggressive and violent behavior in patients and victims
2. Define terms used when managing assaultive behavior
3. Describe the concept of violence
4. Identify theories that describe the relationship between human behavior and violence
5. Identify data collection measures to obtain a patient history in patients with a risk for violent behavior
6. Describe predicting factors that lead to aggression and violence
7. Define the assault cycle
8. Identify general safety principles
9. Describe evasive techniques and strategies to avoid physical harm
10. Describe resources available for coping with incidents of violence
11. Identify appropriate use of medications as chemical restraints
12. Identify types of restraints and restraining techniques
13. Identify measures to prevent workplace violence

Introduction

It seems as though we see it and live with it every day. "It" makes its presence known in films, magazines, video games, and live on TV. We experience it at work and hear about it at healthcare facilities across the nation. "It" affects thousands of working individuals every year.

"It" is occupational violence. According to the United States Department of Labor and the Occupational Safety and Health Administration (OSHA), violence in the workplace results from a variety of internal and external sources.

Workplace violence is not restricted to any one profession and it has the potential to affect anyone of us in a multitude of ways.

Within the emotionally charged field of medicine, healthcare professionals are considered to be at an especially high risk for injury. Whenever and wherever there is any interaction between healthcare workers and patients, or healthcare workers and patient's families and friends, there is a potential for violence.

The Workplace

More than 40 years ago, OSHA mandated that employers must comply with specific standards to protect their employees from hazards that could cause death or serious physical harm (The Occupational Safety and Health Act of 1970). In 1989 OSHA refined their recommendations and published generic health and safety guidelines for all employers to use as a foundation to build their own health and safety plans and programs. The safety programs, still in use today, have never been regulated by any governing body; state or federal government. In fact, most states permit private industry to develop and implement their own unique plans to manage workplace safety.

The creation of individualized work safety programs is problematic due to a lack of consistency and standardization. Safety programs devised by individual organizations may not meet standards in the community or provide detailed safety information. Without appropriate training, employees may lack the skills required to respond effectively to avoid injury or the effects of violence.

Although many years have passed since OSHA's ground breaking safety act, workplace violence continues to occur. To complicate the problem further, there is minimal data available that can be used as evidence to improve existing safety programs.

Test Yourself

Which organization mandated employers comply with standards to protect their employees?

- A. The Joint Commission**
- B. OSHA**

The correct answer is: B. OSHA.

Statistics

The Bureau of Labor Statistics' (BLS) Census of Fatal Occupational Injuries (CFOI) reported more than 13,000 workplace homicides between 1992 and 2010. This averages out at over 700 homicides per year, with the largest number (1,080) of homicides in one year occurring in 1994, and the lowest number (518) occurring in 2010.

From 2003 to 2009, 8 registered nurses were fatally injured at work:

- 4 RNs received gunshot wounds (RNs) leading to their death
- 4 RNs received other fatal injuries

Note: All of the above RNs were working in private healthcare facilities (BLS, 2011 in ANA, 2013).

In 2009 there were 2,050 assaults and violent acts reported by RNs requiring an average of four days away from work (BLS, 2011 in ANA, 2013).

In 2009, the Emergency Nurses Association reported that more than 50% of emergency room nurses had experienced violence by patients on the job and 25% of ER nurses had experienced 20 or more violent incidents in the past three years (ANA, 2013).

Did You Know?

Nearly 60% of all nonfatal assaults and violent acts that occurred in the workplace occurred in the healthcare and social assistance industry (Bureau of Labor Statistics, 2010, in ANA, 2013).

Violence Defined

Violence knows no barriers. It can occur in any culture and affect any socio-economic group of individuals. The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as “violent acts (including physical assaults) directed toward persons at work or on duty.”

In the workplace, violence can be interpreted as offensive language, behavior that is threatening, threats of physical assault, and homicide (Abrella, 2005).

It is important for healthcare workers to understand that the motivation to commit an act of violence is rooted far deeper than the act itself. Violence is an outpouring of strong emotion that can result in danger for the victim and the aggressor.

Any employees that might be exposed to aggressive behavior, threats, and threats of physical harm in the workplace should be provided with training so that they can protect themselves and others. To respond quickly and effectively to an outburst of assaultive behavior, staff will require appropriate training.

Violence can be defined as a harmful and out of control outburst of emotions and actions used to try to achieve a desired goal.

What Causes Assaultive Behavior?

The causes of assaultive behavior are often related to organic disease processes and a variety of behavioral factors.

There are no absolute answers; however, many theories, some of them centuries old, set out to explain the reasons behind human behavior and violence.

Is violent behavior the result of isolation, overcrowding, city life, or a tension between races? Is violence inherent to mankind? Why do human beings act the way they act?

A few examples of these theories will be discussed.

Social Disorganization and Social Learning Theory

Imagine living in a society where the rules changed from week to week. Is it possible that the theories of sociologists such as Florian Znaniecki and W.I. Thomas explain why violence occurs? Thomas and Znaniecki believed in social disorganization. According to the theory of social disorganization, conflict, change, and uneven development within a society will influence the behavior of those within it, sometimes creating an atmosphere that can breed violence (Smith, T., 2011).

Social learning theorist Albert Bandura believed that aggression is a learned process achieved by behavior modeling. He theorized that individuals do not inherit violent tendencies, but learn to model them from observing others or through the media and environment (Isom, 1998). Children will learn aggressive or violent behavior from watching others, especially family members. Bandura stated that since aggression is a prominent feature of the media and a highlight in many television shows, a high degree of exposure may result in individuals expressing a greater incidence of hostility themselves.

Theory of Anomie and Hirschi **Theory of Anomie**

Written in the 1700's, French sociologist Emile Durkheim's theory of anomie refers to a breakdown of social norms where norms no longer control the activities of members in society. According to Durkheim's theory, a lack of clearly defined social rules will lead to conflict, dissatisfaction and deviant behavior. As a society becomes more complex, people are no longer tied to each another; social bonds become impersonal and the potential for social problems such as violence will rise (Criminological Theory, 2005).

Hirschi

Theorist Travis Hirschi stated that one's acceptance of social norms and the development of a social conscience depend on attachment for other human beings. Individuals that have a strong belief, attachment, commitment, and involvement with others will adhere to an ethical code of society. The code contributes to preventing violence and facilitates respect. Without this code, there will be no social conscience and a lack of attachment could lead to violence (Carter, G., n.d.).

Ecological Model

According to the Ecological Model, social, cultural, environmental, individual, and relational factors increase or decrease the risk for violence. The model states that interactions among these factors affect health and well-being and change over the course of an individual's life (CDC, 2009).

This detailed theory defines characteristics or factors that can increase the possibility of being a victim or a perpetrator of violence. Factors include:

(Click on the icons below to reveal details)

Individual factors:

- Prior history of aggression and abuse
- Substance abuse (alcohol, drugs)
- Impulsiveness
- Low educational attainment

Relationship factors with peers or within family environments:

- Lack of parental supervision
- Harsh parenting practices
- Association with others involved in delinquent activities

Community factors:

- High levels of unemployment
- Residential mobility
- Dense population
- Drug trafficking
- Social isolation
- Little institutional supports

Societal factors:

- Cultures that support violence as an acceptable way to resolve conflicts
- Cultures that give priority to parental rights over child welfare
- Cultures that support male dominance over women and children
- High levels of economic or social inequality within groups or countries
- Unequal educational opportunity
- Access to healthcare

These theories represent only a small number of hypotheses that attempt to explain the relationship between human behavior and violence.

Violence in Healthcare

Society today is evolving at a very rapid pace. Technology and scientific advances are reshaping how we live each day. Researchers and scientists are discovering new found cures for what were once considered incurable afflictions. Although this evolution of knowledge has propelled our society to progress, there has been a lack of advancement in understanding the causes of violence.

When considering the potential for violence in the healthcare setting, visions of out of control patients might come to mind. However, not all incidents of assaultive behavior will involve patients. Assaultive behavior may result from interactions between a visiting family member or a friend.

Assaultive, aggressive behavior or acts of violence may be directed at a healthcare worker, a visitor, or another patient. It may even be self directed. Assaultive behavior among staff members might also occur.

Healthcare workers must be educated to develop an awareness of their patients and their environment. They should always be attuned to the possibility for violence.

The Physical Environment

Healthcare workers should learn about the effects of their surrounding physical environment; how a lack of privacy, limited access to bathrooms and a how a climate that is very hot or very cold can lower an individual's threshold for frustration and anger (DHHS, 2005).

The physical environment should take into consideration the need for:

- Privacy
- Safety (including alarms)
- Gender
- Physical space
- Social and religious expression
- Cleanliness

Failure to Report Violence

The Joint Commission (TJC) states that by identifying causes, trends, settings and outcomes of sentinel events (such as workplace violence), critical information can be shared to prevent similar adverse events from happening (TJC, 2006a).

Many facilities withhold reporting incidents of violence or assaultive behavior for a multitude of reasons:

- Administrative pressure or fear of tarnishing a reputation.
- Stigma associated with victimization or feelings of self-blame may also influence a healthcare worker not to report an incident.
- Fear of termination or retaliation by their employer. It may seem easier for staff to ignore an incident than to have to work through it with a difficult administration.

Unfortunately, when acts of violence are not reported, the end result is a missed opportunity for improvement that could have been utilized to reduce risks.

Without accurate reporting of workplace violence, any data that has been collected will not represent all the facts and valuable information to prevent violence will be lost.

Test Yourself

A common reason for non-reporting may include:

- A. Fear of retaliation from co-workers.**
- B. Fear of retaliation from the patient.**
- C. Fear of retaliation from the employer.**

The correct answer is: C. fear of retaliation from the employer.

The Need for Assaultive Behavior Training

After an attack or incident of assaultive behavior, healthcare professionals sometimes describe situations in which patients suddenly and unexpectedly become aggressive, threatening, or violent without any warning signs. In retrospect, it is very possible that subtle warning signs often associated with aggression were not observed and without the proper intervention, the individual began escalating toward an outburst of anger or even worse, an act of violence. Without appropriate training, attempting to manage assaultive behavior can be very dangerous for everyone involved. An employee without assaultive behavior training may present an increased risk to themselves and their employer.

Patient Assessment

As with any patient, a focused assessment should identify risk factors or areas of concern that might indicate aggression or the propensity to become violent.

In addition to obtaining a patient history, collecting information about the patient's psychosocial environment will also help to determine any problem areas.

Set aside time during the patient assessment to develop a relationship of trust as well as time to talk about risks.

Performing a risk assessment: While assessing and collecting data about your patient's medical history, it might become apparent that the patient is at risk for aggressive behavior and/or violence. Incorporating a detailed risk assessment will help plan care that includes specific interventions for managing short term aggressive or violent behavior.

Patient Assessment

Areas to talk with your patient about include:

- Use of weapons in the past
- A history of dangerous or impulsive and aggressive behavior or acts
- Verbalizing intent to harm others
- Substance abuse
- Personal trigger factors
- Recent intense stress
- Social support

Ask your patient about their alcohol and drug use, and explore any feelings of aggression. Determine what the triggers are for aggression and how the patient controls these feelings.

Alcohol

During your assessment, it is important to ask your patient about alcohol use. The use of drugs and alcohol can impair judgment and diminish inhibitions. For the daily drinker, ask what time they had their last drink. Share this information with the admitting physician so that an appropriate medication can be ordered if indicated.

A patient experiencing the initial symptoms of withdrawal may become increasingly agitated or violent. These external (extrinsic) factors can be controlled with supportive therapy and medication ordered by the physician. Because the effects of alcohol in the brain can produce aggression and violence, factors such as drinking history, physical health, amount of alcohol ingested, the time period the alcohol was consumed, and whether the alcohol was taken with other drugs will determine how alcohol will affect an individual.

Small amounts of alcohol (reflected in blood alcohol concentrations) usually produce lowered inhibitions, increased self-confidence, reduced attention span, decreased judgment and slight lack of co-ordination.

Higher levels of blood alcohol can cause aggression and alterations in mood (Boggan, 2003). Of all psychoactive substances, (any substance that results in a temporary change in behavior, mood or perception) alcohol has been shown to increase aggression the most (Roth, 1994).

Ask your patients about alcohol use. Assure them this information is confidential but necessary so you can provide appropriate individualized care. If they seem ashamed or reluctant to discuss this, stress that your role is to help provide care not judgment!

Drugs and Violence

Research indicates that there are strong correlations between violence and psycho-active substances such as drugs, illegal substances, and alcohol.

The overall effects of drugs will depend on the type of drug. Some individuals may experience violent outbursts of behavior after using large doses of street drugs such as cocaine, amphetamines, PCP, and LSD.

Also consider that the behavior could result from a pre-existing psychosis or mental health issue as well.

Test Yourself

Violence may be perpetuated by street drugs, but not by alcohol abuse.

- A. True
- B. False

The correct answer is: **False. Both the abuse of street drugs and alcohol can lead to violence.**

Violence and Mental Health

During your assessment, your patient may report that they have a history of mental illness. Do not assume that they have an increased potential for aggressive or violent behavior. Recent studies have shown that alcohol and substance abuse contribute to acts of violence far more than a diagnosis of mental illness.

The Canadian Mental Health Association (2007) states that individuals with a major mental illness are much more likely to be the victims of violence than other members of society.

According to the United States Department of Health and Human Services Substance Abuse and Mental Health Services (SAMHSA), the overall likelihood of violence is low in individuals diagnosed with mental illness. Yet, people who have been diagnosed with severe psychosis could pose a minimal risk for violence especially if they are not taking their prescribed medication.

Violence can be a factor with individuals who have dual diagnoses such as a mental disorder and a substance abuse disorder.

Cultural and Gender Risk Factors

Cultural and ethnic differences should also be considered when evaluating your patient's potential risk factors for violence.

The past thirty years has witnessed a radical change in the United States racial and ethnic profile. Different cultures interpret body language in different ways. Prolonged eye contact is one example of what might be interpreted as aggressive behavior that might invoke an exaggerated response.

In the past, gender has always been a strong predictor for violence, with men being more violent than women. However, according to the National Institutes of Health (NIH), there is evidence that the ratio of male to female violence is closing by one half (NIH, 2004).

The NIH reports there has been minimal research performed that will help to understand why being male is a risk factor and why females are becoming increasingly more violent.

In some cultures, prolonged eye contact may be considered threatening. In the U. S., fixed staring at an individual is considered confrontational and is known as "mad dogging."

Risk Factors for Adolescents

Research by the CDC indicates that some groups of youth are more vulnerable to become victims or perpetrators of violence than others, such as males from minority groups.

Although many risk factors for youth violence are the same for all the groups, violence that occurs during childhood and adolescence carries through into the adult years. Because of this, the CDC supports early intervention.

The following list of risk factors can contribute to violent or aggressive behavior in youth and is of value when caring for a child or adolescent (CDC, 2012). Factors include:

Individual risk factors for youth:

- Low IQ
- Poor behavioral control
- Attention deficits, hyperactivity, or learning disorders
- Deficits in social cognitive or information-processing abilities
- History of early aggressive behavior
- History of violent victimization
- High emotional distress
- History of treatment for emotional problems
- Involvement with drugs, alcohol, or tobacco
- Antisocial beliefs and attitudes

Risk Factors for Adolescents

Family risk factors for youth:

- Low parental involvement
- Low parental education and income
- Parental substance abuse or criminal activity
- Poor family functioning
- Poor supervision of children
- Authoritarian child-rearing beliefs
- Lax, inconsistent or harsh disciplinary practices
- Low emotional attachment to caregivers/parents

Peer/School risk factors for youth:

- Low commitment to school and school failure
- Social rejection by peers
- Lack of involvement in conventional activities
- Involvement in gangs
- Association with delinquent peers

Community risk factors for youth:

- Large concentrations of poor residents
- High transient level
- High level of family disruption
- Decreased economic opportunities
- Low level of community participation
- Socially disorganized neighborhoods

Test Yourself

Low emotional attachment to caregivers is:

- A. An individual risk factor.
- B. A family risk factor.
- C. A community risk factor.

The correct answer is: B, a family risk factor.

Risk Factors for Geriatric Patients

Within the geriatric population, the causes of assaultive behavior can be grouped into three categories:

- **Patient factors:** Elderly patients with a diagnosis of dementia, organic brain syndrome, or a history of previous assault are most often associated with assaultive behavior.
- **Environmental factors:** Environmental factors that can trigger assaultive behavior include limited body space and excessive environmental stimuli that result in confusion and aggression.
- **Caregiver factors:** Gerontological healthcare workers can help to prevent the incidence of assault by recognizing the potential risk factors associated with fear and anxiety in the elderly. An awareness of each patient's individual needs can help to eliminate patient outbursts of anger, decrease agitation and help in providing a safe and nurturing atmosphere that is cohesive with nonviolence.

Additional Risk Factors: Co-occurrence

Co-occurrence or clustering of risk factors is also a variable to consider in identifying the potential for assaultive behavior. A patient who is a known alcoholic and addicted to cigarettes may become agitated, aggressive, and reach a threshold for violent behavior far more quickly than a patient who does not smoke or drink.

An individual who is ritualistic in their daily lives (i.e. always watch a particular television show or always eat a certain food at a certain time of day) may also become angered when their routine is interrupted and exhibit signs of assaultive behavior.

A patient who has been regularly taking anti-psychotic medications as ordered and attending therapy is less likely to present with measurable risk factors than a patient who has been going without any treatment (DHHS, 2005).

Possessing a particular risk factor does not mean that an individual will be violent; it means that the individual may be more likely to become violent than an individual who does not possess the factor.

Protective and Causal Risk Factors

Factors that can reduce the chance of violence are called protective factors. Protective factors help keep an individual in control of their emotions. Strong and supportive ties to family members and significant others can be considered as protective factors.

Risk factors that can lead directly to violent behavior are classified as causal risk factors. Identifying causal factors that affect an individual may help to predetermine an individual's response to a stressful situation.

A causal factor may be intrinsic (from within) or extrinsic (external). If the causal risk factor is removed, an individual will be more likely to maintain control and an incident of assaultive behavior may be averted.

In addition to performing a thorough patient assessment, developing a plan to observe the patient and the patient's interactions within their surroundings will aid in identifying risk factors for, and preventing assaultive behavior (DHHS, 2005).

Test Yourself

Involvement in a community activity can be described as:

- A. A protective factor against violence.**
- B. A risk factor for violence.**
- C. An activity that does not positively or negatively affect an individual's risk for violent behavior.**

The correct answer is: A, a protective factor against violence.

Identifying Risk Factors in the Environment

The International Council of Nurses (ICN) recognizes that environmental factors can accentuate stress and trigger violence (ICN, 2009). The council suggests:

- Placing security services at main entrances, near visitor's transit routes and in or near emergency departments
- Minimizing access to the facility
- Providing effective lighting
- Providing spacious and quiet reception areas monitored by staff
- Using furniture that can't be used as a weapon (attach chairs together or bolt to the floor)
- Providing distracting activities while people are waiting (reading materials, television)
- Providing comfortable climate control
- Ensuring communication between staff (cell phones, paging system)
- Installing metal detector screening

Managing Assaultive Behavior

Although there are many approaches to deal with violence and assaultive behavior, recognizing the first signs of frustration that can lead to aggression is essential. A basic understanding of human behavior and knowledge of specific communication techniques will assist healthcare workers to identify and sort out risk factors that can contribute to violent or assaultive behavior. Because the ultimate goal to manage assaultive behavior is to stop violence before it happens, healthcare professionals must be provided with training, standardized policies and procedures, and a safe working environment.

Admission to a hospital or other healthcare facility can be an extremely stressful time for individuals, their family and friends. Establishing a supportive relationship between colleagues, patients and their significant others can help minimize misunderstandings and concerns.

Regularly completing a focused patient assessment will identify risk factors that may contribute towards violent behavior.

Learning how to communicate effectively will help facilitate a therapeutic relationship and a mutual understanding of expectations, desired outcomes and goals while at the facility. Despite your efforts to

provide a non-threatening environment, overwhelming stress, fear, and a loss of control may cause an individual to become aggressive or violent.

Obtaining a Patient History from a Patient with Violent Behavior

It may not always be appropriate to get a detailed history and exam immediately. The healthcare professional should remain calm and attempt to gather a rapid history and assessment of the patient's mental state, while attempting to diffuse the situation.

Assess the patient for:

- Signs of aggression, including angry facial expressions, loud speech, refusal to communicate, withdrawal, overt threats, restlessness, violent delusions or hallucinations, or intoxication
- Aggressive behavior and thinking, such as evidence of specific threats to harm self or others, and the availability of a potential weapon
- Risk factors for violence, including a history of violence, or childhood abuse, substance abuse, personality disorder, psychosis or delusions focused on a particular person
- History of physical illness that may impact behavior, such as a recent head injury or metabolic disturbance

Past medical history should identify any known chronic physical disorders that can cause aggressive symptoms, and all prescription and over the counter (OTC) drugs should be reviewed. Patients should be queried about any alcohol or illicit substance use (amount and duration).

Physical Examination

A physical examination may be limited initially to observation and any vital signs that can be obtained. When possible, a full physical examination should be conducted in a safe environment, with more than one healthcare professional present.

A history of violence is one of the best predictors of future violence.

More Info:

When taking a history, note the nature of symptoms and their onset, particularly whether onset was sudden and whether symptoms followed any possible precipitants, such as trauma or change in medications. The healthcare professional should also ask whether patients have had previous episodes of similar symptoms, whether a mental disorder has been diagnosed and treated, and, if so, whether patients have stopped taking their drugs.

Learning to Communicate

As a caregiver, learning to communicate effectively takes practice. It involves the ability to:

- Observe
- Listen
- Respond as needed

It also means maintaining and practicing an emotional balance and focus while under stress. Healthcare professionals should be aware of, and observe for, signs of ineffective coping and increasing levels of stress that might lead to violent behavior.

Therapeutic Communication

Healthcare providers can be instrumental in de-escalating violent behavior and aggression. By practicing therapeutic communication skills, it may be possible to de-escalate a potential violent encounter and restore order for an aggressive patient. You can facilitate effective communication by making sure to:

- Demonstrate that you hear what is being said
- Speak the individual's language (talk on their level)
- Reflect facts and feelings
- Paraphrase and clarify what has been said
- Be sure to ask open ended questions

Demonstrate your concern for an individual by validating that you recognize that they are upset. Statements such as "I can see you are upset" facilitate communication and help the patient calm down as recognition of their feelings is acknowledged.

Stress

Stress can be described as an elevated state of readiness and arousal. Initially, stress can initially improve an individual's performance and help to increase and aid in coping with situations that may seem threatening. A prolonged or too great of an amount of stress will result in a negative effect on the body.

The fight or flight mechanism, also known as the acute stress response, can cause an almost instantaneous increase in heart rate, blood pressure, respiratory rate, diaphoresis, metabolism, and a tensing of muscles. Observable reactions to stress often include social, behavioral, psychological, and physical signs and symptoms.

(Click on the icons below to reveal details)

Social signs of stress include:

- Difficulty in accepting or giving help or support
- Blaming
- Isolation
- Unable to experience fun

Behavioral signs of stress might include:

- Anxiety or fear
- Apathy
- Avoiding certain activities or places associated with stress or negative outcome
- Confusion
- Crying frequently
- Decreased or increased activity
- Denial
- Depression
- Excessive worry
- Grief
- Guilt
- Inability to concentrate
- Inability to relax and rest
- Increase in absenteeism and decrease in job performance
- Memory loss
- Outbursts of anger, irritability

- Difficulty listening or communicating
- Difficulty making decisions
- Euphoria
- Psychological signs of stress
- Substance abuse (drugs or alcohol)

Stress is only one of many risk factors that can contribute to assaultive behavior and the potential for violence.

Physical signs of stress may include:

- Immune system disorders
- Sleep disturbances and fatigue
- Visual disturbances
- Muscle twitching and tremors
- Chills or sweating
- Aches, pains, and headaches
- Problems with gastrointestinal system

Real Time: Reasons for Assaultive Behavior

According to the common knowledge model of assaultive behavior, there are four basic senses that can contribute to why an individual may threaten to injure themselves or others: frustration, fear, intimidation, and manipulation.

Frustration

Frustration is an emotion that can occur when an individual's goals are not attainable within an allocated time frame. The presence of frustration in a person's life can be regarded as a useful indicator of the problems that they are experiencing.

Fear

Fear can be described as a feeling of anxiety and agitation caused by dread, apprehension or by the presence of danger. Fear can be intrinsic (from within) or extrinsic (from an external source). Fear is evoked when an individual feels their well being is under attack or that something essential to them is going to be taken away.

Intimidation

Intimidation can have a number of meanings. Intimidation can mean making someone do something they don't want to (bully) or being made to feel timid or afraid. Intimidation can be communicated by verbal or nonverbal actions (body language). Intimidation can make an individual afraid to try something, or cause a feeling of discouragement due to being belittled by another person's superior wealth, fame or status. Intimidation can cause someone to do something out of fear.

Manipulation

In a behavioral context, the word manipulation can be defined as an action that attempts to influence others in a way so as to get what he or she wants. Manipulation can be used in a dishonest way to cause an individual to falsely believe in something. A manipulator will sometimes provide false information, use false reasoning, distort or withhold relevant information or toy with people's emotions to achieve what they want. A manipulative individual may try to promote confusion by introducing related but irrelevant pieces of information into the conversation. Manipulation is an attempt to get someone to do something they don't want to do (U.S. Department of Labor Employment and Training

Administration, n.d.).

When fear and frustration occur an individual may feel threatened or vulnerable and lose control. When intimidation and manipulation occur, anger may be the result. Anger may lead to an act of violence as an attempt to control the environment.

The Assault Cycle

One recognized method of identifying behaviors that can lead to violence is the assault cycle (Continue CPR, n.d.). Learning and understanding the phases of the assault cycle will help healthcare workers to identify the patterns of escalating behavior and assist them to respond appropriately.

The assault cycle identifies a pattern of behavior that can be observed in many individuals prior to an act of violence. As an individual becomes increasingly stressed about a perceived threat, the intensity of their emotions escalates. Their reaction and response to the threat is cyclical in nature and can be observed in different phases, each one associated with behavioral, physical and psychological responses.

The five phases of the assault cycle are:

1. The triggering event phase
2. The escalation phase
3. The crisis phase
4. The recovery phase
5. The post crisis depression phase

The foremost goal of managing assaultive behavior is prevention.

Test Yourself

Assaultive behavior may be directed toward a primary caregiver, other caregivers, physicians, patients, ancillary staff and visitors.

- A. True**
- B. False**

The correct answer is: True.

The Triggering Event Phase

This first phase of the assault cycle is initiated when an aggressor perceives that there is a threat to her personal well being. The aggressor may experience increasing feelings of frustration that she is being deprived of something of value or that she is being ignored.

During this phase the aggressor may exhibit observable signs that she feels she is experiencing a loss of control.

The aggressor may be reacting to observable stressors such as an argument with another individual, a disturbing phone call, or a loss of privileges of some type (for example not being permitted to smoke or eat when they are hungry).

Non-observable threats could be related to delusions, hallucinations or a reaction to medications.

The Escalation and Crisis Phases

The Escalation Phase

Once an individual reaches the escalation phase, he is preparing to fight. He might verbally challenge the potential victim at this time, especially if the victim is associated with the perceived threat. Behaviors such as yelling, banging, pacing, kicking walls and throwing objects may be observed.

The need for chemical or physical restraints may be identified at this time to prevent progression to phase three if other techniques are failing to de-escalate the behavior. It is important to alert the individual that there will be consequences for the current behavior and that changing his behavior at this time will be beneficial. Special attention to a non-threatening and calm demeanor is important so the individual does not feel even more threatened.

The Crisis Phase

The individual attacks the perceived threat during the crisis phase. Generally this phase does not last long because an individual can't sustain the energy required to continue an attack.

The Recovery and Post Crisis Depression Phases

The Recovery Phase

The individual appears more relaxed during the recovery phase. The individual has not yet returned to baseline yet so another attack could be forthcoming if another perceived threat occurs.

Post Crisis Depression Phase

The individual's behavior may show signs of depression or emotional symptoms of fatigue.

Behaviors that might be observed during this phase include crying, hiding, sleeping, lying in a fetal position, or self blame.

Some individuals may not feel guilt or self blame and may feel empowered or aroused by the violent event.

Be Prepared

Any interaction with an aggressive individual can be extremely stressful even for the most experienced healthcare professional. It is always important to be prepared by asking yourself if you are able to maintain self-control.

In order to control an environment, healthcare workers must maintain self control and not allow a situation or an aggressor to begin to control them.

When dealing with an aggressive individual, learn to:

- Maintain an open and relaxed posture, hands in full view, ready to move quickly but not fearful
- Position yourself at a 45 degree angle slightly off to one side
- Use slow deliberate gestures
- Avoid physical contact or use only in a defensive manner

- Maintain a confident, firm and reassuring voice
- Use a logical calm and encouraging speech content, repeat if necessary
- Leave an unobstructed exit for the aggressive individual

All healthcare professionals should receive assaultive behavior training and be familiar with the Policy and Procedures of their particular organization.

Be Prepared

It is also very important to make sure not to ignore an aggressor's warning signs of a perceived threat. Be alert to the presence of facial tension such as pursed lips, knotted brow, clenched teeth or fists, and tense body language. Remember to maintain control by controlling your own emotions.

Do not:

- Begin shouting or arguing
- Become hostile or punitive
- Ask for explanations of their behavior
- Make dares or threats

Body Language

Try to identify how a patient may perceive you as a threat. Hands held behind your back may suggest a hidden weapon to a paranoid aggressor, or hands folded over the chest may indicate defiance. The nurse's posture is an important factor in escalating behavior in a patient.

Documenting Assaultive Behavior

Written reports of assaultive behavior should be as accurate and as complete as possible and in accordance with facility procedure. Documenting the incident as soon as possible after it occurs will help to maintain its accuracy.

The International Council of Nurses recommends keeping reliable records for statistical support to identify risk factors, development of preventative strategies, evaluation of measures put into place and an analysis of trends (ICN, 2002).

They also recommend that the healthcare worker (victim) involved in an assaultive event and the employer evaluate the management of aggressive behavior together to determine the effectiveness of any current procedures that are currently in place at the time of the incident.

The report should include who, what, where, when, how and why.

Case Study

As you read the case study, try to identify the different phases of the assault cycle:

- 1. The triggering event phase**
- 2. The escalation phase**
- 3. The crisis phase**
- 4. The recovery phase**
- 5. The post crisis depression phase**

Jules has been a registered nurse for about five years. He works in the medical surgical and telemetry float pool at his local hospital. Tonight he has been asked to float to the Emergency Department. After checking in with the Charge Nurse, Jules receives his assignment which includes one of the psychiatric seclusion treatment rooms. The room is currently not occupied and the Charge Nurse assures him that if they receive any “psych” patients, a unit nurse will help him care for his patients.

Around midnight, police arrive with Sheila, a 50 year old female threatening to harm herself and her family. The patient, although combative at the scene, is now cooperative and denies that she would harm herself or anyone else. The police officers report that when they arrived at the patient’s home, Sheila was in the kitchen standing by a knife rack touching the blades of the knives. She has superficial lacerations to six of her finger tips. Sheila’s husband told the officers that Sheila has been irritable and depressed since she lost her job about a month ago. She has been withdrawn from regular family activities and doesn't seem to care about anything anymore. She has been spending a lot of time alone in their room and has been crying even more over the past two weeks.

Jules comments that Sheila smells like alcohol. One of the officers states that there were several empty vodka bottles strewn about the residence. Sheila has not been placed on an involuntary hold; however, according to police procedure, Sheila was brought in for an evaluation.

Jules appropriately asks his colleague, Lisa for help. Before approaching the patient, Lisa calls for security.

More Info:

The arrival of security personnel subconsciously sends a message to Sheila indicating that her behavior is being taken seriously.

The presence of security also demonstrates a show of strength.

Although the patient may appear cooperative now, it is possible that as soon as law enforcement authorities leave, her behavior may change.

Once the Security Officer arrives, Lisa introduces herself and Jules to Sheila, and they both welcome Sheila to the Emergency Department using a calm and friendly demeanor. Lisa tells Sheila that they are here to assist with her care and that there is some essential information she needs to share with her while she is here. Lisa asks the patient if she is thinking of harming herself or others.

When Sheila responds that she does not have thoughts of harming herself or anyone, Lisa, having begun a rapport with the patient, asks her if she would be willing to contract with her not to harm herself or anyone else. Sheila agrees. Lisa also asks Sheila to inform her or Jules as soon as possible if she has any destructive thoughts.

Did You Know?

Although Sheila contracts with the healthcare worker that she won’t self harm or harm others, it doesn’t mean she won’t change her mind!

It is essential to continue to observe Sheila for any signs of fear, frustration or anger.

Lisa explains that the physician will need to examine her and it is necessary for her to dress in a patient gown. Lisa and a security officer accompany Sheila into a private bathroom where Sheila changes into a patient gown and provides a clean catch urine sample.

Did You Know?

It is important to test Sheila's urine for any substances that could affect her course of treatment. This includes drugs such as narcotics, sedatives, or illegal substances.

Jules places Sheila's belongings in a patient belonging bag and gives them to the security officer to label and lock in the patient belonging locker. As the nurse hands the belongings to the security officer, a knife falls from the patient's pants. Fortunately the patient no longer has access to any weapons.

Sheila is escorted to her room where she is instructed that the emergency physician and licensed mental healthcare professional will evaluate her.

Jules wants to close and lock the door to the room so he doesn't have to worry that the patient might leave. Lisa explains that because the patient has not been placed on an involuntary hold, she is technically free to go. The door to Sheila's room must remain open and /or unlocked.

Lisa explains that although Sheila has a legal right to leave, at this point in her care, the emergency room physician would not allow her to do so.

Lisa instructs Jules to be very observant of Sheila's behavior and especially alert to any signs of building tension or frustration so that they can assure that Sheila's behavior will remain under control.

Jules asks the security guards to observe Sheila while he attends to another patient. A few minutes later Jules returns to Sheila's room and observes Sheila pacing about and talking to herself. Sheila's jaw is clenched and she is balling her fists. She sees Jules in the doorway of her room observing her. She advances toward him, screaming that she has been waiting for hours and no one cares about her. Jules notes that Sheila has been waiting approximately 15 minutes and the physician has not evaluated her yet. Uncertain of what to do and feeling a loss of control, Jules abruptly tells Sheila to sit down and be quiet. He turns his back to her for a moment to get the physician. Sheila lunges towards Jules and grabs the stethoscope around his neck, choking him.

Fortunately Lisa and security are right outside the door. Sheila releases Jules and jumps back immediately. She crumples to the floor and begins to cry. Jules, shaken but not injured, leaves the room. Lisa speaks to Sheila in a calm, non-threatening voice. She apologizes to Sheila for the long wait and asks if she is okay. Sheila continues to cry and says she is sorry.

The emergency room physician arrives to interview Sheila. If Jules had maintained in control of his interaction with Sheila, it is more than likely he would not have been attacked.

How should Jules have handled the situation differently?

Instead of yelling at her, Jules could have spoken in a calm, reassuring voice in an attempt to calm Sheila. Instead, his frustration with the situation triggered an assaultive response in Sheila and she attacked him.

Techniques to Avoid Assault

Whenever possible, try to de-escalate an individual before they escalate into an uncontrollable crisis stage and begin an attack. Remember that the goal of managing assaultive behavior is to prevent the behavior before it occurs.

Behavioral techniques to avoid assault include a disciplined approach to controlling your own behavior.

Mechanical techniques to avoid assault include methods of escape to avoid injury. Although these techniques are best demonstrated, there are methods to avoid injury that can be described and include:

- Calling for help
- Staying out of the way
- Encouraging conversation
- Escaping
- Covering up and attempting to escape
- Being patient
- Deflecting the blows and “rolling with the punches”

More Info:

**Never enter a patient’s room alone while they are escalating and never turn your back!
Always remove any objects from your person that the patient could use to harm you or them.**

Choking from the Back

Whenever you turn your back on your patient, you open up an opportunity for your patient to attack. Always try to remain calm and stay in control of the environment. The following images of choking from behind depict one method that can help you to escape.

1. If you find yourself in a situation where you are being choked from behind, immediately raise your arms straight above your head.
2. By raising your arms above your head you will create a small space around the shoulders that can cause the aggressor’s grip to loosen. With your arms up, pivot slightly on your feet in the direction of the door or escape route.
3. As you pivot toward your escape route, twist your arms down forcefully toward the aggressor’s arms, causing her to lose her grip.
4. Run away quickly and call for help!

Choking from the Front

2. If the aggressor lunges for you from the front, try to stay calm and resist the urge to back up.
3. Similar to the back choke hold, immediately raise your arms above your head. This creates an element of surprise and also creates a small space that can cause the aggressors grip to loosen.
4. Pivot your feet in the direction of the door or escape route and as you pivot your feet, twist your arms downward toward the aggressor’s arms.
5. This movement usually loosens the aggressor’s grasp, providing you an opportunity to break free and run for help.

Arm Twist

3. In the event your patient grabs your arm and will not release you, there are many techniques for escape.
4. Resist the common reaction to pull up and away when grabbed by the arm. Instead, push your arm in a rapid downward motion toward the floor.
5. As you pull your arm down, pivot on your feet and move quickly toward your escape route.
6. Run away and call for help!

After the Attack: Staff

Staff members who become victims of assaultive behavior should always report the incident to their immediate supervisor in accordance with the facility policy.

If physical or emotional injuries are present, the employee should be relieved of their duties and evaluated in the emergency department or employee health center as soon as possible.

Offering and arranging for psychological support is extremely important after an incident of assaultive behavior. Signs of anxiety and distress in the victim may be immediately apparent or might not manifest for days or until several weeks later.

Most facilities provide an employee assistance program or will assist the employee to find counseling services within the community. Any concerns or unusual changes in an employee's work habits or emotional status could be a result of the attack and should be reported in confidence to the employee's immediate supervisor. Although some employees may decline formal counseling, it is important to provide them with an opportunity to talk about their experience and submit ideas for preventative measures for the future (DHHS, 2005).

Allocating time after an incident of assaultive behavior is strategic in that it will allow an opportunity to evaluate the incident, provide avenues to understand the behavior, and identify risk factors that might prevent the behavior from occurring in the future.

Proposals to modify any existing prevention plan that the facility has in place can also be accomplished at this time. Immediately after an attack an employee might need time away from work and might ask about filing a report with law enforcement if this has not already been done.

Did You Know?

Staff members who become victims of assaultive behavior should always report the incident to their immediate supervisor in accordance with the facility policy.

Law Enforcement

Sometimes healthcare workers are uncertain if they should contact law enforcement after an attack. Remember to always follow the facility policy and procedure and use common sense.

If anyone in the facility (staff, patients, visitors) becomes a victim of assaultive behavior, the staff member should immediately inform their supervisor and initiate the facility procedure.

An aggressor or perpetrator of an act of violence may go to jail. If the perpetrator of an attack is confused, suffering from dementia or has any disease process that has brought about an altered state of consciousness or confusion, the incident may or may not be considered a reportable incident to law enforcement.

Many facilities recommend that any act of violence committed by a non-patient should be reported to law enforcement and a report should be filed.

Most law enforcement agencies define and categorize violent acts into three areas: simple assault, assault and battery, and aggravated assault (Continue CPR, n.d.).

Types of Assault: Simple Assault

This individual has threatened to injure someone. At the time of or prior to the assault they would likely be yelling and screaming, gesturing and exhibiting signs of anger.

This threat is considered a simple assault if:

- The person is close enough to injure
- The person shows intent to injure
- The person has the ability to injure
- The threatened injury is not serious enough to require immediate medical attention

Types of Assault: Assault and Battery

This individual is trying to injure someone. Most likely they will be yelling, screaming, gesturing, and exhibiting signs of anger. They might be purposely spitting at the intended victim.

This is assault and battery if:

- A person tries to injure another individual
- The person shows intent to injure
- The person makes physical contact
- The person has the ability to injure
- The injury being attempted is not sufficient to require immediate medical attention

Types of Assault: Aggravated Assault

Aggravated assault is assault with the use of a weapon. They might be yelling, screaming, gesturing, exhibiting signs of anger and purposely spitting at the victim.

This is considered aggravated assault if:

- The person has the ability to significantly injure immediately
- The person shows intent to seriously injure immediately
- Threats or attempts of injury would require immediate medical intervention

In the event anyone sustains an injury after an attack (victim or perpetrator); he should receive medical attention immediately!

Care of the Patient: Preventing Further Violence

When attempts to de-escalate a patient are unsuccessful through therapeutic conversation, it may be necessary to utilize other methods to prevent them from injuring themselves or others.

Alternate forms of controlling and preventing a patient from harming himself or others may include the use of:

- Physical behavioral restraints

- Chemical restraints
- Seclusion

These methods must be utilized only after alternate methods have been deemed unsuccessful by qualified personnel.

Behavioral Restraints

If staff had been unable to de-escalate Sheila's behavior, the physician may have ordered that she be placed in seclusion or restraints. After a patient is placed in restraints the physician will frequently order a medication with a sedative effect.

According to The Joint Commission, restraints are the direct application of physical force to a patient, with or without the patient's permission, to restrict freedom of movement. The physical force may be human, mechanical devices or a combination of the two.

Restraint, if used improperly, can cause accidental injury or death. For these reasons, the hospital needs to limit the use of restraints to clinically appropriate and adequately justified situations (TJC, 2010; Centers for Medicare & Medicaid [CMS], 2006).

After a licensed independent physician (LIP) gives an order to place a patient in behavioral restraints, it is extremely important to follow your organization's policies and procedures.

Leather restraints may be implemented; however, some facilities may use cloth restraints. Jacket restraints, also known as "posey's" are not recommended due to the potential for self-strangulation and injury.

Never use a sheet or other device to restrain a patient; as there are many deaths over the years associated with improper restraint techniques (TJC, 2006b).

Remember that a patient should be placed in restraints (also known as personal protective devices) only as an emergency safety measure for the patient and others because all other measures have failed.

Physical assessment of the patient should be performed immediately after the individual is placed in restraints, and as appropriate to the patient's condition, needs, and the type of seclusion or restraint employed.

Waking a patient in restraint or seclusion is not recommended as it can be dangerous for both the staff member and patient/resident/client.

Visual checks should be routinely performed if the patient/resident/client is too agitated to approach (TJC, 2006b).

Once again, remember that restraints are used to protect the patient from harming themselves or others. An order to place an adult in restraints (or seclusion) must be obtained from a licensed independent practitioner (LIP) and re-evaluated every 24 hours (TJC, 2010).

Restraint Tips

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Prior to applying restraints, always inspect the restraints for any tears or defects and be aware of the specific restraints policy and procedure for your facility.

If leather restraints will be used, inspect the leather and metal hard-wear. Since restraints come in different sizes, make sure you have two wrist restraints and straps as well as two ankle restraints and straps. You should have at least one key for the primary caregiver and one key for security personnel.

Restraints should always be secured to the bed frame, never to any movable part of the bed such as a side rail.

The patient should be restrained lying supine on a bed or gurney with one arm positioned up toward the head and the other arm in a neutral position toward the feet. Each ankle is also restrained. All four restraints should be tethered to the bed to allow slight patient movement but not so loose that the restraint could become twisted or caught on the bed. An inch or two of slack on the tether should be adequate.

The patient's limbs should be repositioned frequently (arm position reversed). Since the goal of restraints is to de-escalate the patient and remove the restraints as soon as the patient is no longer at risk, the patient should be evaluated per your facility policy to determine if they are no longer a safety risk.

A patient is never:

- Restrained in the prone position (due to the possibility of suffocation)
- Restrained by the arms or legs only
- Restrained by one limb only
- Unobserved for longer than 15 minutes (continuous monitoring is recommended)

When it has been determined that your patient no longer requires restraints, do not immediately remove all four restraints. Your patient has experienced an extremely stressful outpouring of emotions and may still be labile and lose control, harming themselves and others. If your facility policy and procedure does not address removing restraints, consider removing one wrist and one leg restraint first. Never perform this task alone.

While removing the restraints, utilize this time to perform a continuous evaluation on your patient's emotional and physical status. Be certain to remove the restraints from the patient's immediate vicinity (a restraint can be used as a lethal weapon).

If your patient meets criteria to proceed with removing all four restraints, remove the remaining restraints. Remember that your patient's emotional status could change at any time and you must remain alert to signs of frustration and aggression that could result in another cycle of violence.

For additional information on restraints, please see RN.com's course on restraints.

Chemical Restraints

Chemical restraints are medications that restrain an individual's behavior. Medications that are used during an acute aggressive state are different than medications used for long term care.

Agitated patients should be offered medication as soon as possible to assist in calming them down.

Medication should be individualized based on the patient's history and medical condition.

Psychiatric evaluation should be performed as soon as possible to determine whether other problems that increase aggression such as psychosis, substance abuse, or anxiety are present.

Since certain medications may depress respirations, it is important to follow the facility policy and procedure for monitoring patients that receive sedation.

Medications Used to Treat Aggression

Examples of medications used to treat aggression include:

Benzodiazepines

Benzodiazepines such as lorazepam (Ativan®). Lorazepam can be very effective when given for acute episodes of aggression and can be administered orally, sublingually, intramuscularly or intravenously. Staff who administer benzodiazepines should become familiar with potential side effects such as decreased level of consciousness and respiratory depression.

Antipsychotics

Antipsychotic medications such as haloperidol (Haldol) and chlorpromazine (Thorazine®) are useful during an acute episode of aggression. Haloperidol is a neuroleptic medication that can be given orally, intramuscularly or intravenously. It can have a longer lasting effect on agitation but may be associated with increased adverse effects. Other antipsychotic medications include Clozapine (Clozaril®), olanzapine (Zyprexa®), ziprisdone, (Geodon®) and risperidone (Risperdal). Patients that receive antipsychotic drugs should be observed for side effects such as altered level of consciousness, respiratory depression, seizures, dystonia and dyskinesia.

Antidepressants

Antidepressants can be used to reduce anxiety, irritability and fear. All of these emotions can progress to aggression or assaultive behavior and should be addressed. Medications such as amitriptyline (Elavil) and fluoxetine (Prozac) should be used with caution-it has been blamed for causing homicidal or suicidal behavior) may be used.

Mood stabilizers

Mood stabilizers such as Valproate (Depakene) can also be used to treat aggression. Valproate, Divalproex (Depakote®) and carbamazepine (Tegretol) are usually used for long term therapy in the treatment of a number of psychiatric conditions such as dementia. Lithium carbonate (Eskalith®) is sometimes used to reduce aggression during manic episodes.

Beta-adrenergic blockers

Beta-adrenergic blockers, such as propranolol (Inderal®), have been used for long term therapy to treat aggressive behavior in a number of diagnoses, including dementia, posttraumatic brain syndromes, postencephalitic psychosis, and chronic central nervous system dysfunction. Using propranolol for aggression however does have a high frequency of adverse cardiovascular effects.

Note! Although the above medications can be used to manage aggression, they are also prescribed for other conditions such as depression, panic attacks/anxiety and psychotic episodes.

Seclusion

There may be times when a patient must be placed in restraints and seclusion. Patients such as these need to be continuously monitored by trained staff either in person or through the use of both video and audio equipment that is in close proximity to the patient (TJC, 2010).

The seclusion room should not contain any items that the patient could use to injure themselves or others. The room should be free of equipment including any wall suction apparatus or tubing of any sort.

It is extremely important that the patient being placed into seclusion is clothed in a hospital gown and their belongings removed from the room.

Entry to the room should be restricted to the primary caregivers and security. Ancillary team members such as lab technicians or respiratory therapists should never enter the room alone.

Nothing should enter the room that could be used as a weapon. At meal time, food should be served on disposable plates and in disposable cups.

Whether a patient is placed in restraints or in seclusion, healthcare workers should never perform any interventions without security personnel or a fellow healthcare worker standing by. The potential for injury remains high. Patients may have been able to wriggle free of restraints and be waiting for an individual to come within striking distance or they may attack healthcare personnel upon entering the seclusion room.

Did You Know?

**Always lock up patient belongings, especially their shoes, in the patient belonging cupboard.
Most patients who could pose a flight risk (elope) will not do so without their shoes!**

Involuntary Treatment

The National Association of Psychiatric Health Systems reports that about 88% of adults treated in its members' hospitals are admitted voluntarily.

In many states, people who are very disabled by their illnesses and who refuse hospital treatment may be involuntarily admitted to the hospital, but only by law enforcement, a trained physician or other licensed individual per state approval.

An involuntary hold is usually for a period of 72 hours (three days).

Involuntary treatment is sometimes necessary and is always subject to a review which protects the civil liberties of the individual.

When a Physician is not Available

TJC requires facilities to establish policies regarding monitoring the restrained patient. These policies should include the following guidelines:

- When a facility is unable to provide an assessment by a physician within one hour of a patient being placed in restraints, the registered nurse will confer with a physician (or other individual permitted by the facility and the state) within one hour after the seclusion or restraint is initiated
- The RN will document in the record the reasons why the patient has not been seen within an hour, and will assess patients in restraints every hour until the assessment is performed by the physician or other appropriately licensed individual

- Nursing staff should recognize that all behavior has meaning and evaluation is the best means to respond to behavior
- Physiologic considerations and meeting patient's needs, such as comfort measures, pain relief, evaluating for the development of complications of illness (i.e. fever) should be explored
- Staff must be educated to provide educational opportunities for nurses to develop the necessary assessment and intervention skills that will prevent the use of restraints
- Formal policies and mission statements should be adopted and clearly state an intent to promote a reduced restraint environment

Position Statements about Restraint Safety

Over the years, there has been numerous documentation of patient injury and even death with the improper use of restraints. Organizations such as the National Alliance on Mental Illness (NAMI), Substance Abuse and Mental Health Services Administration (SAMHSA), the American Nurses Association (ANA), and the American Psychiatric Nurses Association (APNA) have all published their position on the use of restraints and seclusion as an option to control behavior.

NAMI:

The National Alliance on Mental Illness (NAMI) is a national grassroots mental health organization dedicated to improving the lives of individuals with serious mental illness and their families. NAMI was founded in 1979 and is a national voice on mental illness. NAMI states that involuntary seclusion and mechanical or human restraints is justified only as an emergency safety measure in response to a patient or other individual's safety.

According to NAMI, restraints and seclusion have no therapeutic value. The organization recommends that restrained patients are evaluated by a licensed independent mental health professional (LIP) or a physician trained in psychiatry within one hour of initiating restraints.

SAMHSA:

In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced their vision to reduce and ultimately eliminate the use of restraints and seclusion in behavioral healthcare settings. SAMHSA believes that restraints and seclusion result in injury and trauma and are detrimental to the recovery of individuals suffering from mental health issues. The organization states that staff fear an increase in injuries if seclusion and restraint use is eliminated but that according to their research, the number of injuries actually decreases. Their national action plan, Roadmap to Seclusion and Restraint Free Mental Health Services, establishes the need for eliminating the use of seclusion and restraints in favor of creating an environment where all viewpoints are heard. The American Psychiatric Association (APA) and the The Joint Commission (TJC) also have guidelines regarding restraints and seclusion.

American Nurses Association:

The American Nurses Association (ANA) position regarding restraints is that restraints should only be utilized when no other viable option is available and that nurses must be actively involved in the assessment, implementation and evaluation of the intervention (DHHS, 2000).

American Psychiatric Nurses Association:

The American Psychiatric Nurses Association (APNA) recognizes that the ultimate responsibility for maintaining standards of care and maintaining the safety of those in the treatment environment rests

with nursing and the facility. Because of this, the APNA supports a commitment to the reduction of seclusion and restraint use. APNA also supports evidence based practice and advocates professional standards that will promote and ensure the physical safety of the patient and others. The organization recommends continuous observation of all patients that are placed in restraints.

Planning for Prevention

Preventing violence in the workplace begins with planning. Planning should be a shared activity among various individuals from different areas. Administrators must plan, devise and put into place policies that address safety measures into the work environment. Managers must ensure that staff receive appropriate training and are informed of and adhere to the facilities policies and procedures.

Although violence in the workplace continues to occur with sometimes horrifying outcomes, there are no sanctioned federal regulations in place. And, despite new developments in understanding human brain development and the human genome, there has been minimal incorporation of this information applied toward the prevention of violence. Information about understanding the standards of behavior in cultural and ethnic groups have not been addressed either (DHHS, 2005). Without a standardized plan or prevention strategy, the risk of workplace violence will remain a serious hazard to healthcare employees. The field of violence prevention needs reliable, valid measurement tools to determine the effectiveness of previous years of violence intervention techniques (Dahlberg et al., 2005).

Even though a facility may have developed individualized plans for managing assaultive behavior, individualized plans are inherently flawed because they lack national standardization. Non-regulated training plans have:

- An increased potential for miscommunication due to subjective interpretation of plans
- A lack of standardized language
- Inconsistencies related to the facility or unit specific needs
- Increased potential for errors

NIOSH

One of the National Institute for Occupational Safety and Health's (NIOSH) objectives is to develop a national workplace violence research and prevention initiative for all types of workplace violence. Research would be translated into practice by presenting findings, recommendations, and approaches to workplace violence prevention.

Violence affects us all at some level. The National Institutes of Health (NIH) recognizes that violence is an issue of vital national and international importance and supports funding to promote the dissemination of violence prevention programs that have been found to be effective. According to the NIH, many interventions aimed at reducing violence have not been sufficiently evaluated or proven effective, and a few widely implemented programs have been shown to be ineffective and perhaps harmful. They state that programs that seek to prevent violence through fear and tough treatment seem to be ineffective.

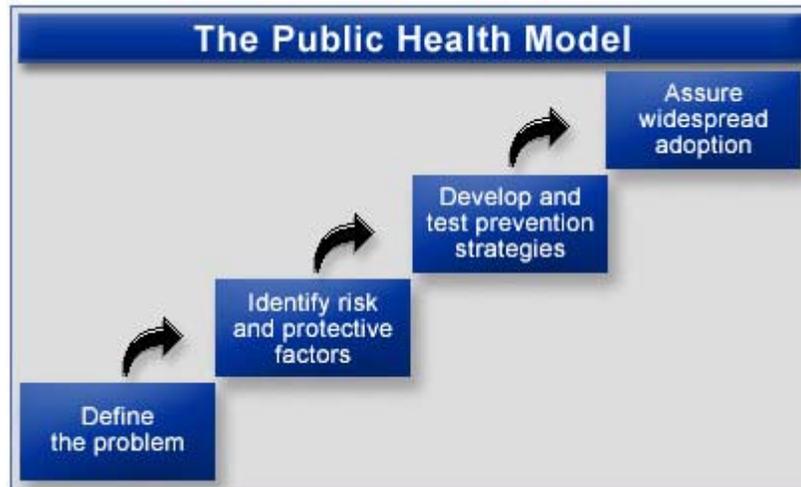
The International Council of Nurses recognizes that inadequate training has been identified as a major contributing factor to the prevalence of assaults and training in managing assaultive behavior can reduce injury.

The Public Health Approach to Preventing Violence

The public health approach to violence emphasizes primary prevention. Primary prevention is a four

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step process that starts with analyzing surveillance data about the location of violence; the victims of violence, the perpetrators, and trends. After analyzing surveillance data, step two is to identify any risk factors associated with violence. The third step is to design prevention programs and evaluate their effectiveness. The fourth step is to implement interventions that have shown positive results.



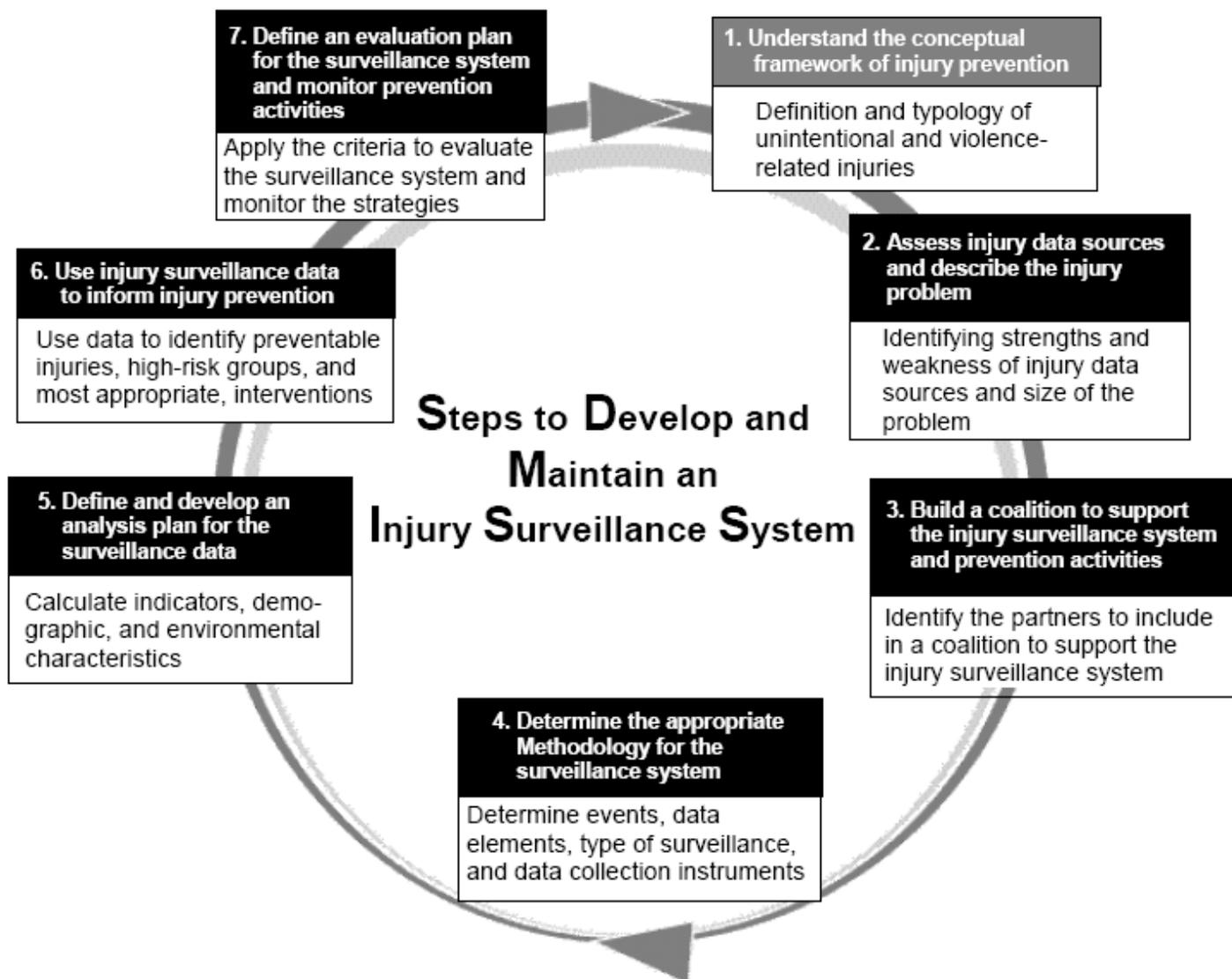
<http://www.cdc.gov/ViolencePrevention/overview/publichealthapproach.html>

CDC Surveillance System

The CDC has developed a surveillance system for injury prevention that requires an understanding of the conceptual framework of injury prevention with seven steps (CDC, 2005).

According to the CDC, injuries account for a significant health burden on populations, no matter the age, gender, income, or geographic region. In response to this burden, the CDC developed an injury surveillance system to collect, analyze and interpret injury data. The data is used for planning, implementing, and evaluating prevention activities. The process for injury surveillance is cyclical in that certain steps may be repeated to meet the needs of developing evidence based practice.

According to the CDC, the first step in the process is to be familiar with the conceptual framework of injury prevention. The second step is to describe the size of the injury problem and the data sources. The third step involves considerations to support injury surveillance and prevention activities. The fourth and fifth steps specify the technical skills needed to develop the surveillance system. The sixth step translates data into prevention activities, evaluation, and monitoring activities.



The International Council of Nurses Standpoint

The International Council of Nurses (ICN) has developed guidelines for nurses to cope with the possibility of violence in the workplace.

The recommendations recognize the importance of a supportive and positive organizational climate to ensure that nurses are aware of their responsibilities and rights.

The ICN philosophy embraces the importance of acknowledging that violence in the workplace will never be tolerated (ICN, 2000).

The ICN has also identified key factors that identify methods to decrease workplace violence.

They include:

- Developing multidisciplinary safety policies
- Fostering joint decisions between physicians and nurses
- Making continuing education programs available

- Maintaining staffing and quality of staff at optimal levels
- Establishing support structures such as counseling, debriefing teams

7 Tips to Prevent Workplace Violence

Crisis Prevention Institute (CPI) is an organization that provides training to healthcare professionals in de-escalating violence in the workplace, and provides training in managing disruptive and assaultive behaviors.

CPI offers a short YouTube video on 7 Tips to Prevent Workplace Violence:

(Copy and paste this link to your internet browser to view)

<http://www.youtube.com/v/2leLuzA77yM>

Conclusion

Learning to recognize the signs of assaultive behavior and preventing behavior that can escalate and lead to violence is essential for the safety of today's workforce. To help maintain a safe working environment, healthcare workers rely on effective policies and procedures, their ability to identify risk factors, the signs of a pending attack, and how to control an environment in order to prevent the attack.

Although we may never be able to explain why people act the way they act or why they become violent, we can learn to identify emotional and behavioral clues that might prevent such an act. Learning and applying communication techniques to diffuse escalating and potentially assaultive behavior is usually much more beneficial to caregivers than allowing the aggressive behavior to occur and attempting to counter the attack by learning to perform defense maneuvers.

Healthcare workers and others at risk of violence will greatly benefit from receiving standardized training that will assist them to recognize aggressive and assaultive behaviors. The primary goal of learning to manage assaultive behavior is always to preserve safety, dignity and prevent assaultive behavior before it occurs.

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