

Handling violent or aggressive patients: a plan for your hospital

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Abstract

Small rural hospitals by nature have difficulty handling the violent or aggressive patient. A successful plan for preparing staff to deal with these cases involves teaching staff how to anticipate when violent or aggressive behaviour may occur, where in the emergency department to place a potentially violent patient, when to request more help, proper body language to employ and the preparation of a protocol for placing emergency restraints.

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Résumé

De par leur nature même, les petits hôpitaux ruraux ont du mal à faire face au problème des patients violents ou agressifs. Pour instaurer avec succès un plan d'action qui prépare le personnel à affronter ces situations, il faut notamment leur apprendre à prévoir les comportements violents ou agressifs, leur indiquer à quel endroit du service d'urgence il faut installer un patient qui risque de devenir violent, quand il faut demander de l'aide et quel langage corporel utiliser. On doit également prévoir un protocole de contention d'urgence.

As rural physicians we face many hurdles in dealing with the violent or aggressive patient: our staff lack experience in dealing with such individuals; our hospitals often lack "safe rooms," where a patient can be kept without danger to him or herself or others; there is often a lack of adequate security personnel, especially during evening and night hours; distances to specialized

units are far, and we often lack clear referral paths to psychiatrists, who are not in oversupply.

Much of the literature on the prevalence and type of violent or aggressive behaviour in the emergency department has come from US¹ or Canadian² tertiary care or inner city hospitals, and these studies are of unknown relevance to rural emergency departments. One small study suggests that violent and aggressive behaviour in rural areas may be more common than is thought. A recent survey of 11 small-town and rural hospital general emergency departments in Quebec found that 96% of the hospital workers surveyed had been victims of verbal aggression, either by the patient or by someone accompanying the patient. Forty-two percent of emergency workers had been the victim of an act of physical violence during the past year, almost always by the patient.³

In that study, hospital staff members appear to have been poorly trained for encounters with violent or aggressive patients. Only 36% of those surveyed stated that they had received some training in how to deal with the aggressive "client"; however, the training appeared to give them confidence: 78% of the workers who had some training felt they could handle an aggressive patient situation adequately, but only 50% of the workers who were not trained felt that they could handle such a situation.³

The time for planning on how to deal with violent or aggressive patients is now, not at the proverbial 3-am encounter. We submit the hospital plan for the Centre de Santé Temiscaming because we believe it is adaptable to most rural health care facilities. Although it is not a comprehensive review of the topic of violence in the emergency department, we believe this protocol is an example of one hospital's attempts to realistically plan and educate staff for the violent and aggressive patient. We believe the basic matrix of this protocol, subject to local adaptations, is suitable for any rural hospital. This plan was developed primarily as an educational and policy tool for the nursing personnel.

High-risk factors associated with violence in the emergency department include alcohol or drug abuse and being male.¹ Although we recognize that both male and female patients are capable of being violent and aggressive, for ease of reading, we refer to the patient as "him" throughout this article.

Although aggressive behaviour can be a symptom of medical or psychiatric illness, most violent behaviour in our society is simple criminality, unrelated to illness. It is often better handled by the police, the prisons and the courts. However, deciding if such behaviour is the result of disease requires a medical and mental status evaluation, the results of which will not be available when that patient is wheeled into your emergency department.

1. Medical and psychiatric causes

The vast majority of patients with psychiatric diseases are never aggressive, dangerous or violent.

Causes of aggressive and violent behaviour in the emergency department are many^{1,4} and include 4 broad categories: Psychiatric Diseases, Organic Brain Syndromes, Drug and Alcohol Abuse, and Personality or Behavioural Disorders.

A. Psychiatric diseases

- Acute mania. This is a relatively common psychiatric cause in our experience. It can be deceptive because the person may be outwardly quite pleasant and jovial — until angered!
- Schizophrenia, especially the paranoid variety. This is quoted as being a common cause of emergency department violence in the US literature,¹ but in our experience it is less common than mania.

B. Organic brain syndromes

By this term we mean confused and occasionally aggressive behaviour when the brain's functioning is disturbed by illness (e.g., encephalitis, hypoglycemia) or head injury, or else by disturbed metabolism (e.g., DTs, drug withdrawal). The hallmark is said to be disorientation, a fluctuating level of consciousness and abnormal vital signs.¹ Our experience is that this is more a problem of the older, in-patient than the emergency department patient.

Mental retardation or dementia. Diagnosis is usually well known to the caregivers and is often obvious to the medical personnel.

C. Drug and alcohol abuse

Drug and alcohol abuse is quite a common cause of violent or aggressive behaviour, in our experience.

D. Personality or behavioural disorders

People with antisocial personalities or borderline personality disorders can be quite noisy and aggressive. These people usually are not classed as having psychiatric illnesses. They can be difficult to handle because they cannot be "talked down," and are often more properly handled by hospital security or the police.

"Acting out" or hysteria, especially in adolescents. These individuals can actually get quite aggressive.

2. When to be on the alert for the possibility of aggressive or violent behaviour

As in any problem, forewarned is forearmed. It is important to know when aggressive or violent behaviour is likely to occur. Consider the following scenarios.

- Family or friends use words such as "out of control," "wild," "crazy" or "angry" to describe the patient.
- Patient is brought to the emergency department restrained by friends, the police or the ambulance attendants.
- Patient is under the influence of drugs or alcohol.³
- Patient has been known to have indulged in violent behaviour in the past, either toward others (e.g., spouse) or has behaved violently in the emergency department (Dr. Alan Buchanan, Associate Clinical Professor, University of British Columbia, Vancouver, BC: personal communication, 1999).

High-risk factors associated with violence in the emergency department include alcohol or drug abuse, and being male.¹ We believe that a history of violence in the past is also a risk factor. A Quebec study found that violent behaviour is more likely to occur at night; this is perhaps related to longer waiting times or to more prevalent alcohol and drug abuse during these hours.³

3. Who should you call for help?

A. On call physician

The physician on call will be needed for diagnosis and treatment.

B. Police

Remember, most violent and aggressive behaviour is criminal in nature, and therefore should not be dealt with via the health care system. Call the police immediately if the patient

- makes any threats, verbal or physical;
- acts destructively (e.g., hits the walls, destroys equipment, hits someone);
- is noisy, hyperactive and won't quiet down after one or two requests;
- is armed (e.g., gun, knife, broken bottle).

Do not inform the patient that you have called the police — this may make him even more aggressive ("I'll take them all on!"). Do not try to negotiate with a person displaying this level of aggression.

If, after you have called the police, the patient seems to quiet down on his own, do not call off the police. Allow the police to come and evaluate the situation. The physician will

evaluate whether it is safe to allow police to leave.

C. Ambulance attendants

If the patient requires more security than can be offered by the nursing staff on duty, or if help is needed to apply or adjust restraints, call the ambulance attendants. (Note: Our hospital has an agreement with the ambulance technicians for them to provide this service.)

D. Administrator

If you have called the police, you should probably inform the administrator on call.

4. Triage: where to place an aggressive or potentially violent patient

A. Patient already in restraints

When the patient arrives already in restraints placed by the ambulance attendants or the police, move him into the Crash Room. This is usually the largest treatment room in the emergency department, large enough to accommodate several persons without crowding the patient, and with enough space to allow staff to manoeuvre even when the patient is on a stretcher. Any medical or monitoring equipment you might need is nearby. Ask any accompanying relatives or friends to remain until you have had time to do a more complete assessment. Initially, do not remove the restraints — this may make the patient more aggressive.

B. Patient not in restraints, but high-risk

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

C. Low-risk patient

If you feel that the patient is low risk, (i.e, is quiet on arrival, not on alcohol and is older), he may be taken to one of the examining rooms in the outpatient department. Rooms that

have exits at both ends are preferable so that no one feels trapped. Remove any sharp objects from the room beforehand. Leave at least one of the doors open, if possible.

5. How to act in the presence of aggression^{1,5-7}

A. Two's company

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

B. Stay calm

If the patient is angry and aggressive, speak slowly and politely. Try not to show anger yourself. (This is difficult to do, but showing your anger will only worsen the situation.) Introduce yourself and ask why he is angry or simply ask him to tell you about himself. (Antisocial persons usually love to brag about themselves.) Certainly, don't argue back, and don't agree with the patient if he has any delusions or bizarre ideas. Say that you'd like to help. Allow the patient to "ventilate" a bit, without becoming judgemental yourself. Often, in our experience, after a few minutes the patient does calm down.

If the patient is simply angry, remember that sometimes he may have reasons for that anger: he may be in pain, may have waited hours in a crowded waiting room, may be stressed because of a sick spouse or child. Even a simple statement such as: "I know that you are angry about the 2-hour wait, but it's hard for me if you're yelling. Why don't you tell me what I can do for you, and I'll try to help you out?" may help tremendously. Remember that a little empathy sometimes goes a long way!

C. Position yourself carefully

How far away from the patient should you stand? Stand about 1.5 metres (4 to 5 feet) in front of him, but a bit off to the side; do not face him directly. This is close enough to allow you to develop a rapport, but far enough away so that you do not threaten his personal space and he can't easily touch or hit you. Don't turn your back on him, and always approach him from the front.

D. Body language

Adopt a submissive pose: arms relaxed and hanging down at the side, palms open below your waist and facing the person, shoulders drooping, legs relaxed. Don't look directly into the patient's eyes because this is threatening to most people; focus your eyes on his

chin. This is perceived as less threatening, and you can see his hands easily.

E. Offer a snack

Offer the patient juice, biscuits, a soft drink, and maybe have some yourself. Sharing food is a natural bond between people, and people aren't as likely to argue if they're eating. If the patient is really insistent on a coffee, give it to him, but be aware that he can always throw a hot drink at you. Sitting down together and talking or eating also forms a bond, but do not sit down if the patient refuses to sit down, and make sure you don't sit in a corner, where you can be trapped.

F. Check for weapons

You may decide to check a purse or pockets for weapons, especially if the patient is being admitted.

G. Too hot to handle

Although violence can occur quickly and randomly, in most cases there is some advance warning: anger, agitation, a clenched-fists posture, loud behaviour, yelling.¹ An important rule for nursing staff is that if the patient suddenly stands up and starts to yell or wags or points his finger at you, **GET OUT OF THE WAY AS QUICKLY AS POSSIBLE!** This patient is too hot to handle.⁵ No heroics! Back out of the room quickly. Run if you have to! If there are two of you on duty, run off in opposite directions (he can't chase both of you). If you are really scared, lock yourself into a bathroom or run out of the building if necessary. Carrying a portable phone is a good rule — you can call for help.

We believe that a violent patient is unlikely to hurt the other patients and that the staff is more at risk. If the patient runs out of the hospital — let him go. The physician can then decide whether or not to call the police.

6. Use of restraints

If you are concerned for the safety of the patient or staff, it is permissible in an emergency to apply restraints prior to the arrival of the physician on duty.

View the application of restraints as a procedure, like handling a patient with cardiac arrest. Know when it is necessary and work according to a plan, with teamwork and a clear team leader. Inform the patient: "We are going to have to put you in restraints to help us protect you" (or, "to protect ourselves"). If the patient appears to consent, fine, but once you've decided to apply restraints, don't discuss or negotiate further with the patient. Apply the restraints as quickly and

humanely as possible. Even if the client calms down afterward, the nurses should not remove the restraints. The physician should decide when to do this.

It may be safer to leave the person in a lateral position because aspiration could occur. A soft neck collar may also protect the patient and it makes it more difficult for him to bite someone.

Obtain a written medical order for the restraints as soon as possible. Don't leave a restrained patient alone in the room, and be sure there is some kind of monitoring regime in place. Watch the patient's head — he can still bite.

Summary

For the rural physician, the message is clear. Be sure your hospital has a proper plan for handling the violent or aggressive patient. This plan should specify the resources available, who should be called, and where to put the patient. Train your staff in proper procedure and body language for dealing with this difficult clientèle. Debrief your staff after an incident. Discuss how the situation went, what was done well and what could be improved on the next time.

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