



## **Management of the Violent Patient in the Emergency Department**

Hostile and aggressive patients are frequently encountered in the emergency department. The emergency physician must be prepared to make rapid decisions regarding the protection of staff as well as the patient. Emergency department intervention and subsequent disposition of the violent patient will be presented in this course. Issues of physician liability during the use of chemical and physical restraints will also be presented. Appropriate documentation guidelines for restrained patients will be reviewed. State-of-the-art sedation techniques for the violent patient will be explained.

- Describe the indications for the restraint of patients.
- Describe the methods for physical and chemical restraints.
- Describe appropriate documentation for the restrained patient.
- Develop a plan for monitoring the restrained patient.

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### **FACULTY**

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## Violence Prevention in the Medical Setting

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Violence is a public health problem of epidemic proportion. The danger to health care providers in professional settings escalates as violence moves off the streets and into the medical setting.

Violence is not an inescapable part of our lives. The reduction of violence in our offices, clinics, and hospitals requires that we make violence personally and culturally intolerable. Optimal patient care is achieved only when patients, visitors, and health-care workers are protected against violent acts occurring within the health-care setting. A safe working environment is conducive to improved staff morale, and enhanced productivity.

Medical personnel must develop strategies to prevent victimization. Preventive measures include the control of environmental factors that may provoke those with violent tendencies and graded management options including verbal or psychological intervention, show of force, and physical and/or chemical restraints. The key to violence reduction is the early recognition of potential violence by a calm and prepared health care provider. Occupational health and safety laws say employees must be provided with a safe working environment and safe systems of work. Employers should prepare a plan to identify, assess, and control potentially threatening or violent situations and incidents at work. The management plan should include procedures to cope with and defuse potentially violent situations, alert co-workers, call police and provide personal protection, personal alarms, or self-defense training.

### Legal Vulnerability

Each hospital needs comprehensive risk-management guidelines.

- Duty to protect  
litigation for:
  - failure to restrain or detain violent patients
  - failure to protect patients, visitors, staff
- Duty to use the least restrictive techniques necessary  
litigation for:
  - detention/seclusion/restraint or injury during restraint process
  - assault and battery
  - false imprisonment

*A suit for assault and battery and false imprisonment is easier to defend and less likely to be successful than a suit for wrongful death. The legal liability, for both harm and legal damages, is likely to be lower if health care professionals err on the side of preventing violence*

Restraining a patient raises serious concerns, such as:

- infringement on patient autonomy and freedom of movement
- claims of battery
- risk of physical and/or psychological injury resulting from the restraints

Patients and staff have a right to be free from violent assault, but it must be balanced against the right of patients to be free of unnecessary medication and restraints.

Since the widely adopted ruling of the California Supreme Court in the Tarasoff case of 1974, the violent acts of patients released in the community have become a serious legal problem for health professionals. Medical personnel may be held responsible for failing to notify authorities if they know a violent patient has made clear threats to harm a specific person(s).

#### Impediments to quantifying the full extent and magnitude of workplace violence

- There is a lack of a uniform definition of violence or the severity of the incident

aggressive  
violent  
abusive  
dangerous

disruptive  
destructive  
threatening

- We have a high threshold for reporting incident and a reluctance to notify police and file charges  
*our perceived professional responsibility to the patient overrides our feelings about the abusive incident*
- Denial:  
" I try not to dwell on it. It won't happen again."  
" It really wasn't that bad, I'm OK."
- Rationalization:  
" He was ill/upset/drunk...."

#### Personal safety questions for your employer

Is there adequate security coverage?  
Does the ED treatment area and hospital have secured exterior doors?  
Are security assessments done to determine risks and vulnerabilities?  
Are there training opportunities for the staff?  
Is the staff educated and equipped to deal with violent or disruptive behavior?  
Does the administration support an aggressive stance against violence?

Costs:

- police involvement
- medical evaluations
- physical and psychological therapy
- temporary hires
- employee assistance programs
- loss of security
- loss of personnel
- loss of productivity
- decrease in morale

Workplace violence is the leading cause of occupational death for women and third leading cause of death for all workers.

**Death is a high price to pay to practice one's profession.**

Associated Factors of Aggressive Behavior:

There are no clear and definite predictors  
for who will and who will not be violent.

Common ages

- senility
- adolescence

Intoxicants

- alcohol
- stimulants
- recreational drugs
- withdrawal states

Injuries/illness

- head trauma and hemorrhage
  - subdural
  - subarachnoid
  - intracerebral
- seizure disorder
  - postictal state
  - temporal lobe epilepsy
- CNS infections
- diabetes mellitus, hypoglycemia
- respiratory distress, hypoxemia
- hyperthyroidism
- Cushing's syndrome
- hyperthermia, hypothermia

electrolyte imbalance  
vitamin deficiencies

Psychiatric

Organic Mental Disorders  
Organic Personality Disorders  
    borderline  
    antisocial  
Delirium  
Paranoid delusions  
Psychosis  
    particularly Schizophrenia  
    Bipolar Affective D/O in manic state.

Demographics

young, male  
live in poverty  
live in environment of decreased social control  
( live in environment where violence is part of everyday life)

Weapons      knowledge, skill, and access

Situations

gangs  
time delays  
trauma: *heightened anxiety*  
confrontation of perpetrators  
simultaneous evaluation of the victim and perpetrator  
incomplete understanding of English and/or the US culture  
disabled police officers: *accessible weapons*  
patients in police custody: *low security, high risk for escape attempt*  
grief reaction: *some cultures condone aggression as an expression of*  
*grief*  
distraught patients or visitors: *increased risk of misperception*

Violence Prevention Strategies:

Patient interaction

allow a family member to stay with the patient and calm them  
limit the visitors (traffic) in the treatment area  
screen visitors for trauma patients (avoids the potential for

restitution)

institute liaisons between patients and families (improves communication)

Interviewing techniques:

honest, straight forward and frank  
but not overly friendly

- avoid excessive eye contact
- avoid entering the patient's personal space
- trust your "gut" feelings
  - if you feel uncomfortable, reassess the situation
- observe the patient for:
  - tense posture
  - provocative behavior
  - angry demeanor or threatening and/or loud speech
  - tough, intimidating stance
  - hypervigilance
  - staring
  - signs of agitation:
    - tremors
    - sweating
    - pacing
    - clenching of fists, teeth and hands
    - pacing
    - pounding walls
    - throwing furniture

Interview setting- "*privacy but not isolation*"

- give yourself unrestricted access to the door and emergency buttons/exits
- store or remove supplies/equipment which could be used as weapons

Staff protection

- professional training
- first names only on name tags
- increase staff assertiveness and unity
- limit access to staff information (phone number, address, schedule)
- stop the attitude- "*it (violence) comes with the territory*"

Personal measures:

- obtain training and education
- dress for work
  - comfortable clothes, low shoes, safe jewelry
- tuck ties in shirt, avoid stethoscopes hanging around your neck
- set realistic deadlines for the patient and visitors
- don't divulge personal information
- summon security as soon as danger is appreciated
- review your institutions policies regarding filing charges against a perpetrator
- learn defusing techniques
  - maintain personal space
  - allow some degree of venting
  - ignore personal affronts
  - avoid arguing or defending
  - avoid threatening body language
  - calmly and firmly set limits

In a situation:

- calmly state, without issuing hostile commands, that violence will not be tolerated

in	<p>Do not ignore threats:</p> <ul style="list-style-type: none"> <li>no threat of violence is harmless</li> <li>failure to respond may make an angry patient feel that he is not being taken seriously</li> <li>set limits                         <ul style="list-style-type: none"> <li>violent patients may become even more agitated when they sense that others are not control</li> </ul> </li> </ul> <p>remain calm, ensure help is on the way</p> <p>if attacked- maintain your own airway</p> <p>find and use shields</p> <p>move quickly</p> <p>maintain a safe distance, allow a buffer of at least two arm lengths</p> <p>stand sideways to the threat                         <ul style="list-style-type: none"> <li>this is a less provocative and intimidating stance, and provides a narrower target reducing exposure</li> </ul> </p> <p>if the situation warrants, use chemical and/or physical restraints</p> <p>if you have the potential to get hurt, let the patient leave</p> <p><b>No Heroics</b></p>	
	<p>if the patient has a weapon</p> <ul style="list-style-type: none"> <li>ask the patient to place it on the floor, then both leave the room</li> <li>do not try and retrieve the weapon</li> <li>let police disarm patients</li> </ul> <p><b>Once the situation is under control, differentiate between an organic or functional cause of the violence</b></p>	
	<p>Departmental policies:</p> <ul style="list-style-type: none"> <li>separate patients with minor illnesses from those with major illnesses</li> <li>institute security, restraints, and strategies- <b>before</b> <ul style="list-style-type: none"> <li>* injecting Narcan</li> <li>* attempting any intervention in an escalating patient</li> <li>* separating a child from an angry, intoxicated, or psychotic parent</li> <li>* telling an angry psychiatric patient of a hospital transfer</li> </ul> </li> </ul>	
	<p>Departmental policies (cont.):</p> <ul style="list-style-type: none"> <li>train staff in the proper use of restraints</li> <li>use a minimum of five people to restrain a patient</li> <li>undress all psychiatric patients- examine clothing and personal items for weapons</li> <li>give immediate attention to any agitated patient or visitor</li> <li>realize that restraining a patient intent on leaving is <b>not</b> a job for medical staff</li> <li>warn all hospital staff, referral physicians, and authorities of a patient's violence</li> <li>notify authorities if a violent patient leaves the hospital</li> <li>obtain a psychiatric evaluation on violent patients</li> <li>assign the "right" personnel                         <ul style="list-style-type: none"> <li><i>staff may unknowingly escalate a patient's agitation</i></li> </ul> </li> <li>unacceptable:</li> </ul>	

snappy retorts  
intolerance of complaints  
ignoring requests for information  
failure to recognize physical or verbal signals  
overreaction to people or situations

Administrative policies:

Document all incidents  
Develop a supportive protocol which includes:  
    attention to health care- both medical and psychological  
    counseling- both psychological and legal  
    independent and objective review of the incident  
Develop a process to review all incidents  
    allow the staff to discuss the event and determine the cause  
Have a security management plan  
    define responsible personnel and issues  
    develop security procedures for all conceivable situations  
    set up protective and surveillance devices, alert systems  
    enforce identification and limited access

Facility requirements:

Install security lighting and protective barriers  
Improve surveillance and the ability to monitor any offensive behavior  
Provide sufficient numbers of professional career security officers  
    the mere presence of security personnel does not insure a  
        safe department  
    appropriate selection and training are essential  
    well trained and responsive  
    specifically trained in aggression management  
Consider Metal detectors  
    expensive  
        hand held vs. stationary  
    require specially trained officers  
    screen all: walk in patients, visitors and ambulance patients  
Cameras  
    must be manned  
    high risk if it is a dummy" camera, or unmanned  
Actively patrol all parking areas  
Maintain multiple methods for instantly summoning the police  
    panic buttons not telephones  
    well rehearsed responses  
Conduct mock crisis drills  
Develop a violence alert mechanism: notifies ED and hospital staff

Facility requirements (cont):

Have special secure rooms  
    seclusion room                      police room  
    grieving room                      psych room  
Consider bullet proof glass at the registration area  
Restrict access to the hospital and emergency department



locked or security coded entry and exit doors  
Make the ED more habitable  
redesign waiting areas to provide welcoming, calming surroundings  
decrease crowding and noise  
soft lights  
clean waiting room and bathrooms  
refreshments  
telephones  
parental responsibility for children

Verbal and Physical Interventions:

Training programs should stress verbal strategies and non abusive physical strategies:

- Verbal techniques
  - show concern and respect
  - speak in a calm, slow voice empathizing with the patient's concerns
  - talking softly is particularly effective when a patient is loud and belligerent
  - acknowledge their anger and direct it toward an appropriate cause
  - behave politely, and listen uncritically and actively
  - remain nonjudgemental
  - do not attempt to "correct" the patient's perception
  - do not take the person's anger personally, even when directed at you
  - tell the patient what you want of him, not what you don't want
  - give the patient options (preferably three options), not ultimatums
    - ex. you may either sit in the chair, lie on the stretcher, or be restrained
  - an offer of food, drink, or medication reduces the patient's anxiety
- and
  - demonstrates concern
  - avoid hot drinks or potential weapons(eating utensils, plates)
  - avoid "why" questions
    - they may be perceived as an attack
  - avoid emotional or judgmental comments
  - do not make promises you cannot keep
- \* verbal techniques are rarely effective in an intoxicated, psychotic, delirious or extremely agitated patient**
- Physical techniques (training in the following)
  - team restraints
  - moving, walking and carrying a person
  - escapes from simple holds
    - wrist grips
    - bites
    - hair pulls
    - clothes pulls
  - escapes from life-threatening attacks: ex. front and back chokes

Restraints:

## Physical Restraints

Restraints are any physical or pharmacological means used to restrict a patient's movement, activity or access to their body.

Patients have a right to be free from restraints unless the restraint is necessary to:

- prevent imminent harm to the patient or other persons  
when other means of control are ineffective or inappropriate
- prevent serious disruption of the medical evaluation and treatment
- prevent significant damage to the physical environment
- to treat the patient's medical symptoms

The FDA estimates that at least 100 deaths from improper use of restraints may occur annually.

- reports of burns, broken bones, and other injuries related to patient restraints
- many problems with restraint devices are never reported to the FDA

Prior to using restraints, consider the following:

### Risks:

Aspiration  
Suffocation  
Neurovascular compromise and its sequelae  
Rhabdomyolysis  
Skin breakdown or injury

- carefully weigh the benefits against the risks
- consider other alternatives
- use the least restrictive method of restraint
- restraints may never be used for discipline or staff convenience
- obtain a written order which includes:
  - time limitation
  - type of restraint
  - clinical justification of the necessity for restraint
  - a monitoring tool for reassessment, attention to patient needs, neurovascular checks

ED personnel may initiate restraints in an emergency situation prior to obtaining the written order, but it must then be obtained within one hour.

Effective 2 Aug. 1999: Section 482.13 of COBRA/EMTALA regulations on patient rights set new guidelines limiting the use and duration for chemical and physical restraints as well as seclusion.

Under this regulation, as Federal law, the standards are that the order for

restraint or seclusion cannot be written for more than:

4 hours for an adult

2 hours for children ages 9 to 17

1 hour for patients under 9

the original order can be renewed up to a maximum of 24 hours, before requiring that the practitioner see and reevaluate the patient

The regulation states that "a restraint can only be used if needed to improve the patient's well being and less restrictive interventions have been determined to be ineffective".

General recommendations:

- \* Find alternatives to using restraints whenever possible.
- \* Use with patient or family consent.
- \* Discontinue use as soon as feasible.
- \* Observe patients in restraints frequently.
- \* Remove the restraints as often as possible to allow for normal body functioning and daily activities.
- \* Apply and adjust the restraint so that it is comfortable for the patient.

Follow the manufacturer's directions to:

- \* select the type of restraint recommended for the patient's condition
- \* use the correct size for the patient's weight and height
- \* note the front and back of the restraint and apply correctly
- \* tie knots that can be released quickly
- \* secure bed restraints to the bed springs or frame, never to the mattress or bed rails. With an adjustable bed, secure the restraints to the parts of the bed that move with the patient

Documentation:

Document: assessment, intervention and outcome including:

- Patient behaviors requiring the restraints to prevent or manage the behavior
- Less restrictive interventions used, which were unsuccessful in re-establishing patient self-control.
- Patient cooperation sought in implementing safety interventions. Specific interventions employed and patient response.

Management of the patient:

If verbal interventions have failed move to the next level of intervention

### **Show of Force**

5 people as a minimum

One person to control the head and one person for each extremity.

One person to serve as the leader and four followers.

Initially gather around the leader with an image of confidence.

The leader states "come calmly or you will go in restraints".

The leader states the reason why restraints are needed.

Give the patient a few seconds to back down.

If the show of force fails then move to

**The Take Down:**

At the signal of the leader each extremity is controlled and one staff member holds the head.

Control is most easily obtained by immobilizing the major joints.

The patient is brought to the floor in a backward motion and then rolled over.

(extremely agitated patient's may require the prone position, most should be restrained in the supine position, consider the side position for the elderly or ill to prevent aspiration)

Restraints are then applied

Debrief:

Discuss the events with the staff and later the patient to aid in prevention of further incidents.

Chemical Restraints

Agitated patients are a danger to themselves and others.

The immediate goal of treatment of the acutely agitated individual is to reduce the agitation, irritability, and/or hostility to a level where the patient is not a physical danger to himself or others and to a level where they can be medically managed. This may involve the use of antipsychotics and benzodiazepines either alone or in combination. The rationale behind the combination approach is to take advantage of the anxiolytic/sedative effects of the benzodiazepine and allow for a lower dose of the antipsychotic.

Benzodiazepines:

Lorazepam

Diazepam

- Lorazepam
  - generally better than Diazepam
  - less dependence on liver metabolism
  - shorter half life
  - more consistent IM absorption
  - nonsclerosing to veins

Both medications are available as PO, IM and IV

Both are readily available

PO of both work almost as quickly as IM

Antipsychotics:

most common chemical intervention in the management of agitated patients usually administered IM or IV due to difficulty of PO in these patients.

no significant difference in efficacy between IM and IV administration

one antipsychotic has not been demonstrated to be more effective than

another in rapid treatment of the agitated psychotic pt.

low-potency antipsychotics, i.e. chlorpromazine,  
associated with a higher incidence of hypotension  
high-potency antipsychotics, i.e., haloperidol  
associated with a higher incidence of acute extrapyramidal side  
effects (EPS)

- Haloperidol
  - not FDA approved for IV use although frequently used
  - can be used with many causes:
    - psychosis, organic brain disease, CNS pathology, metabolic
    - and endocrine abnormalities, drug induced delirium
  - patient remains responsive to commands and not sedated
  - avoid in:
    - PCP overdose
    - withdrawal syndromes or drug intoxication with anticholinergic properties
    - pregnancy and lactation
  - has been associated with Neuroleptic Malignant Syndrome (NMS)
    - rare side effect
    - autonomic instability with hyperthermia, hypertension and rigidity
    - at risk patient:
      - young, chronically psychotic
      - dehydrated, malnourished
      - poorly ventilated room
      - physical restraints

Saline flush to prevent precipitation with Heparin and Phenytoin.

Mild agitation: start with 0.5 mg- 2.0 mg.

Moderate agitation: start with 5 - 10 mg.

Severe agitation: may need to start with 10 mg.

If the patient remains agitated, doses can be doubled every 20 to 30  
minutes and can be safely increased to hourly bolus doses of up  
to 75 mg

Haloperidol can be given through IV drip.

A recommended rate is 10-12 mg/hour.

Start low for the elderly and pts. with debilitating illness.

Hypotension is a rare side effect.

- Droperidol
  - has FDA approval for IV anesthetic use.
  - has a higher incidence of hypotension and sedation
  - NMS is rare
  - Dose 5- 10 mg IM or 2.5 -5 mg slow IV, followed by additional  
increments of 1.25 mg to 5 mg

Recommendation:

- Haloperidol 5 mg IM/IV or PO q 30 minutes until calm.
- Benzotropine (Cogentin) 2 mg IM/PO/IV or Diphenhydramine(Benadryl) 50 mg IM/PO/IV q 4 hour prn EPS.
- Haloperidol 5 mg IM/IV or PO with Lorazepam 2 mg IM/IV or PO q 30 minutes prn until calm.

Alcohol withdrawal states

for agitation, tremors: Librium 25-50 mg PO q 4-6 h and Magnesium Sulfate

for elderly: Lorazepam 2 mg PO q 2 h

for extreme agitation: Lorazepam 2-4 mg IM. IV

Cocaine or amphetamine intoxication

mild or moderate agitation: Diazepam 10 mg PO or Lorazepam

severe agitation: Thiothixene or Haloperidol

Pain as the major precipitating factor

Opiates: Morphine or Demerol

Why is there an increased risk of violence in the ED?

easy, open access

used as shelters

wide range of clientele

24 hour accessibility

increased violence in society

increased prevalence of gangs

minimal to non-existent security

prolonged waiting times, overcrowding

distrust of physicians, nurses, and EMS (perceived as the 'establishment')

increased prevalence of drug and alcohol abuse in society

used for medical clearance of alcohol and drug related arrests

"fast food" mentality- *patients and family expect instant results*

over controlling environment- *provocative to some personality types*

"10 ways to safer ED" Hospital Security and Safety Management - Aug. 1989

1. greater access control and visibility of all ED entrances: walk-in and ambulance
2. use of metal detectors
3. installation of silent alarm systems connected to either the hospital security office or a local police department

4. implementation of strategies to make the waiting time more pleasant
5. use of closed-circuit television to monitor all hospital entrances
6. maintenance of dedicated rooms for seclusion and treatment of psychiatric or potentially violent patients
7. formation of cooperative agreements with local law enforcement with specifics on checking their weapons, offer a police room for completion of paperwork and interrogations
8. assignment of the "right" kind of personnel to ED duty  
not everyone can handle the stressful situations encountered in ED's on a daily basis
9. separation of patients with minor illnesses from the more seriously ill
10. use of the services of on call psychiatrist to allow ED personnel to express their feelings after a particularly bad shift

#### Guidelines for dealing with Gangs

- Transport rival gangs to different hospitals  
If not possible: alert the hospital
- Avoid treating rival gang members within close proximity
- Immediately involve hospital security and local officials
- Disrobe the patient and search clothing for weapons
- Educate the staff about recognition of local gangs
  - tattoos                      colors
  - typical clothing          hand signs
  - accessories                evidence of prior trauma
- Directly question the patient, family and visitors about gang involvement
- *Do not challenge or disrespect gang members*
- Limit access to visitors
- Identify patients as John or Jane Doe
- Never release information over the phone  
including the patient's actual presence
- 24 hour gang educated hospital security
- Consider metal detectors, bullet proof glass

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[www.medlaw.com/whatsnew.htm](http://www.medlaw.com/whatsnew.htm) for full text of HCFA Patient Rights regulations.