AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
SCIENTIFIC ASSEMBLY
1999

Violence in the Emergency Department

Despite extensive security, the emergency department is still subject to violence. The lecturer will review the scope of the problem of violence in the emergency department. Learn behaviors of staff that can exacerbate potentially violent situations, and learn behaviors to help avoid such confrontations. Measures to help reduce the threat of violence will be discussed, including policies, procedures, and security measures.

- Discuss the common precipitants to violence in the emergency department.
- Identify staff behaviors that may exacerbate a potentially violent situation, and identify behaviors to avoid violent confrontations.
- Discuss methods to help reduce and effectively manage violent situations in the emergency department, including policies, procedures, and security measures.

MO-59
Monday, October 11, 1999
5:00 PM - 5:55 PM
Room # N223
Las Vegas Convention Center

FACULTY

Stephen R Hayden, MD, FACEP

Associate Professor, Medicine, Department of Emergency Medicine; Program Director and Research Director, Emergency Medicine Residency; Hyperbaric Medicine Attending Staff, Hyperbaric Medicine Center, University of California, San Diego Medical Center, San Diego, California

Violence in the Emergency Department

- Statistics
  32% Emergency Departments have at least one verbal threat daily
  18% Emergency Departments have at least one threat with a weapon each month
  Over a 5 year period in some ED's, 57% ED staff threatened by a weapon
  - 43% reported a physical attack on an Emergency Department staff at least once each month
  - 7% Emergency Department's reported violence resulting in a death in the past 5 years

  25 % Emergency Departments report at least one patient per day required restraint

- Violence occurs most commonly in
  Age <30
  Male
  substance/ETOH abuse
  Patient brought in by police
  Psychiatric problems (paranoia), personality disorders

- May also occur in patients with:
  Psychiatric (manic states, antisocial personality)
  Organic brain syndrome
  CVA
  CNS infection
  Substance abuse

Case 1

17 yr old male is brought in by police from a private residence where a group of high school students were having an unauthorized party. Friends reported he had been drinking a punch spiked with grain alcohol, they denied any other drugs or pills but did state one person had said they were doing some GHB earlier. On arrival O2 sat 96%, BP 130/88, P 50 sinus brady, RR 14, T 98.9°. The patient was unconscious but reacted to sternal rub by looking like he was going to push your hand away. He was protecting his airway, no respiratory distress, and had ETOH on breath. His head was shaved with no evidence of trauma, his lip, tongue and eyebrow were pierced, he had multiple tattoos and exam was otherwise unremarkable except for above decreased level of consciousness.

You order an IV, O2, EKG, BAL and monitor the patient closely. BAL comes back shortly at 0.240, EKG normal and patient seems a little more arousable, you continue to monitor and observe the patient.

Sometime later, you hear yelling and screaming down the hall and you find the patient awake, out of bed with only his underwear on, being held by one ED tech and the patient yelling obscenities at an African American patient in the next bed, spitting on floor, saying "get this f---in piece of ---- out of here or I am going to kick his ---."

How do you handle this situation? What strategies can you use?

Case 2

37 yr old male brought in by police for threatening his girlfriend, he is an ex-IVDA that admits to smoking marijuana earlier in the evening. It took 5 police officers to wrestle him down and cuff him initially. In the back of the police car he became increasingly combative and began thrashing about and hitting his head against the side rear window. The police stopped the car, medics were called to the scene and promptly placed him in a c-collar/backboard and used 2 full rolls of tape to keep him immobilized and transport him to your ED.

On arrival he is described as a thin individual, about 155 lbs, yelling and screaming to "take the f---in collar off and get me off the backboard". He is very agitated, pupils are 5mm bilaterally with horizontal and vertical nystagmus and he is straining at the tape that binds him. He has an abrasion to the right side of his scalp. P 130, BP 170/98 per medics, fingerstick glucose in field is 117, 18g IV in his left AC. A family medicine intern initially evaluated the patient as you are just pushing thrombolytics on a patient in your acute care area. The intern just learned about clinically clearing c-spines and as there is no history of major trauma or ETOH, and the patient has no apparent distracting injuries, he undoes the tape/collar. Soon after you are called stat to this area of the ED to find the patient with his back to the wall near the nurses desk, dripping blood from the IV site, ready to rush 3 ED techs and 2 security guards that have circled in front of him. The family medicine intern is nowhere to be seen.

What do you do?

Case 3

14 yr old male is brought in by police for threatening suicide. He is the son of a police captain who called his girlfriend (whom he just broke up with) and told her he was going to blow his brains out with his fathers' .38 special. In the ED he appears sullen, eyes downcast but looks up and around quickly every now and then. He refuses to disrobe, lie down, or talk to the nurse. He does not appear to be an acute danger to staff, is grudgingly cooperative and out of respect for this father the nurse puts him in a quiet room at the end of the corridor with police just outside the door but there is a large window in the door to observe the patient. How do you proceed to workup this patient?

You find the patient to be cooperative, answers questions appropriately, says he'll see a psychiatrist, and denies any medical problems. When you ask the patient to undress, he takes off his coat and sticking out of his pants is the .38 caliber hand gun.

How do you proceed at this point? What if the weapon were a drawn knife he won't give up?

Key issues Case 1:

Talk patient down
Remove other patient from room quickly, quietly
Be calm, don't escalate situation
Have security called (show of force)
Be firm, set limits, outline consequences of violent behavior
Don't let patient get between you and the door
An offer of food/drink may elicit cooperation

- Key issues Case 2:

Take down patient
- Run take down like a code
- Each person with specific assigments
- One person per body part
- Practice this during ED "downtime", regular drills

Restraints
- Know how to apply
- Legal issues, advisement
- Courts support use of restraints but must document concern for patient and staff safety, and proper ongoing assessment
- Other means failed or not appropriate
- Written order
- Describe what behavior needed to remove restraints

Maintain universal precautions
Chemical restraints
- Combination of Lorazepam/Haldol or Droperidol is best choice

Don't forget appropriate medical workup

- Key issues case 3:

Remain calm
See if he'll voluntarily give up the weapon to security
- Have him lay it down on table

Assure patient evaluation will continue <u>after</u> the weapon is given up
Explain to him you don't want anyone to get hurt and ED policy requires the gun be put in a safe place
If agitation/tension increase, don't escalate, calmly excuse yourself and let police handle
Strategies to deal with/prevent weapons
- Metal detectors, searches, security personnel

Trust your gut, if you feel unsafe you probably are
Remain calm, remove self/staff from harm
Use mattress technique?

- Summary

- Take demands and aggressive behavior seriously, should be high triage category, don't ignore
- Interview in private setting but not in isolation, always have an escape route
- Remain calm and professional at all times, commanding or macho behavior from you will escalate situation
- Try and calmly talk patient down first, be gentle but firm
- If your gut tells you that the situation is unsafe, it usually is, listen to it and get yourself out of danger

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