Module 2 – Unit 8: Reading & Vocabulary

Dealing with Violent Patients

Think About It Read the situation and statistics below. Then answer the questions that follow.

“I was working with one other nurse on an isolated unit when an older woman with dementia became like a prize fighter – kicking, scratching, and hitting us. It was like she had super-human strength, and she surprised us. I ended up with black and blue marks and scratches everywhere.”


In a study in which nursing aides in nursing homes were surveyed, it was found that:

• 59% were assaulted at least once a week.
• 16% were assaulted daily.
• 51% had been injured during an assault.
• 38% had received medical attention for an assault-related injury.


1. In what settings might health care professionals encounter violent patients?
2. What factors might cause patients to become violent?
3. Have you ever encountered violent patients in your job?
4. What can health professionals do to prevent violent situations with patients?

Read the article below and answer the questions that follow.

Dealing with Violent Patients in the ED

Emergency physicians encounter violent patients as predictably as they encounter blocked airways. Fundamentally, the approach to violence in the ED is comparable to the approach to the airway. There are many reasons that airways are blocked, yet regardless of the cause, the physician must control the airway before subsequent treatment. Similarly, violent behavior is an endpoint for many different medical and psychiatric
pathologies, and the emergency staff must control the behavior to prevent escalation and injury, before moving on to further evaluation.

Since the **definitive** medical or psychiatric diagnosis in these patients is often not possible in the emergency situation, it is **imperative** to have a clear management approach to violent patients.

### Causes of violent behavior and strategies for managing it

Violent behavior may be an appropriate response to a given set of environmental circumstances. Individual responses to environmental situations will be affected by many factors such as personality characteristics (or disorders) – aggressiveness, poor impulse control, and antisocial or **manipulative** traits. Emotions, especially fear, powerlessness, anger, and rage play a role in the tendency for violent actions, and may be most responsive to verbal intervention.

Any violent behavior in the ED should be considered a **pathological state** that could lead to morbidity or mortality; therefore, appropriate prevention or intervention becomes necessary. A history of violence, regardless of diagnosis, is the most consistent predictor of violent behavior in the ED. Many EDs have a system for documenting and notifying ED staff about patients with prior violent visits to the ED.

Recognizing the potential for **deterioration** of existing psychological defenses in a patient already exhibiting pathological behavior is the best assurance for the safety of patients and staff. Three progressive but integrated strategies can be used: de-escalation, restraints and seclusion, and pharmacologic interventions. The “least restrictive alternative doctrine” requires that the **least invasive** methods be used to control violent patients. The remainder of this article will focus on the least restrictive strategy, de-escalation.

### De-Escalation

The apparent chaos of the ED may contribute to the behavioral deterioration of patients at risk, but there are environmental variables that can be addressed to help lessen the potential for this. Waiting times, frustrating for anyone, can be minimized. Placing at-risk patients in a quiet or private exam room will decrease external stimuli. Patients may need to be separated from other loud or aggressive patients, friends, or family. Alternatively, those same people can be called upon for support if they are cooperative. Show your concern for a patient’s well-being by offering comfort in the form of warm clothing or blankets, a chair or stretcher, food or drink. Question patients early and directly about weapons or potential weapons, and remove them.

When talking to the patient (verbal de-escalation), the **overriding principle** is that staff convey their professional concern for the well-being of the patient, that the staff be in control, and that no harm comes to the patient. When you are with the patient, be sure that you have a means of leaving the space you are in. You should be closer to the door
than the patient, but you also need to be aware that you shouldn’t convey a feeling of entrapment. Also, be aware of your body language. Crossed arms, hands behind the back, leaning forward, and prolonged or intense eye contact can be seen as threatening or challenging. Respect personal space.

When speaking to at-risk patients, it is important to maintain a calm, controlled tone. Never express anger or hostility, and never minimize or “write off” patient threats or feelings. Express your empathy and concern. Statements such as, “I understand you are feeling frustrated, that you’re having a hard time,” and “you’re here to get help; let’s try to figure out what’s going on,” convey both. Emphasize to these patients that they are safe, and that the staff is there for them. However, you also need to clearly define limits for patient behavior, and consequences of their actions. Provide reasonable alternatives to aggressive behavior. It is crucial that staff be consistent in their approach because manipulative patients may attempt to split staff who do not have a unified strategy.

Always be alert for changes in patient mood, loud and aggressive speech or actions, and increasing psychomotor activity, which may signal loss of control in the near future. The ultimate measure for impending danger is the caregiver’s visceral perceptions (gut reactions). If one feels unsafe or threatened in the face of a potentially hostile patient, it is best to end the interaction until interventions have begun. Security personnel or local police can be called upon to help prevent inappropriate or dangerous behaviors. They can also be instrumental in assisting with physical restraints and containment.

Sometimes, in spite of your best efforts at de-escalation, patient behavior will deteriorate. If less restrictive efforts are unsuccessful, restraints, seclusion and/or medication may be used in response to imminently dangerous behavior.

Once the decision has been made to proceed with restraints or seclusion, there must be sufficient trained personnel so that the procedure can be carried out safely and effectively if physical force becomes necessary. At all times, the staff must convey confidence and calmness, and proceed with implementation as if it were a routine procedure. Violent encounters are stressful for both patients and staff and can contribute to deterioration of morale, depression, and anxiety. It is appropriate to have some type of debriefing that offers the opportunity for staff to discuss the event and the associated feelings.

Steps to Preventing and Responding to Violent Behavior

1. General response to disruptive behavior (no threats or weapons)
   - Respond quietly and calmly.
   - Do not take the behavior personally.
   - Ask questions.
   - Consider offering an apology.
   - Summarize what you hear the individual saying.

2. If step 1 is ineffective and the individual does not seem dangerous
Calmly and firmly set limits.
Ask the individual to stop the behavior and warn that action may be taken.
If the disruption continues despite a warning, tell the individual what action will be taken.

3. If step 1 is ineffective and the individual seems dangerous

- Use a calm, non-confrontational approach to defuse the situation.
- Never touch the individual yourself.
- Signal for assistance.
- Get yourself and others to safety as quickly as possible.

Adapted from:
- [http://www.ferne.org/Lectures/violent%20patients%200501.htm#I](http://www.ferne.org/Lectures/violent%20patients%200501.htm#I), Retrieved 4/24/05.
- UC Davis Division of Human Resources.
  [http://www.hr.ucdavis.edu/Employee_and_Labor_Relations/work_place_violence/05_Brochure](http://www.hr.ucdavis.edu/Employee_and_Labor_Relations/work_place_violence/05_Brochure), Retrieved 4/24/05.

Questions About Reading

1. Explain the analogy of dealing with airways and violent behavior in the ED.

2. What internal and external factors may contribute to violent behavior in the ED?

3. List the least invasive steps that can be followed to prevent a potentially violent situation. Which of these actions do you think will prove most effective when dealing with a patient who may become violent?

4. If de-escalation is unsuccessful, what other strategies can be used? If these more invasive measures are taken, how can staff carry these out safely and effectively?
Vocabulary Practice

Read the sentences below from the article. Then choose the best meaning for the underlined word or phrase in each sentence. Circle the letter.

1. There are many reasons that airways are blocked, yet regardless of the cause, the physician must control the airway before subsequent treatment.
   a. happening before something else
   b. happening at the same time as something else
   c. happening after something else

2. Since the definitive medical or psychiatric diagnosis in these patients is often not possible in the emergency situation, it is imperative to have a clear management approach to violent patients.
   a. fully formed and completely developed
   b. initial or beginning, can be doubted
   c. likely to change later on

3. Since the definitive medical or psychiatric diagnosis in these patients is often not possible in the emergency situation, it is imperative to have a clear management approach to violent patients.
   a. unnecessary
   b. essential
   c. not important

4. Individual responses to environmental situations will be affected by many factors such as personality characteristics (or disorders) – aggressiveness, poor impulse control, and antisocial or manipulative traits.
   a. able to control or deceive people in order to get what you want
   b. having the ability to handle objects skillfully
   c. good at moving joints or bones in the correct position

5. Any violent behavior in the ED should be considered a pathological state that could lead to morbidity or mortality; therefore, appropriate prevention or intervention becomes necessary.
   a. a violation of state law
   b. a logical pathway
   c. an maladaptive mental condition
6. Recognizing the potential for deterioration of existing psychological defenses in a patient already exhibiting pathological behavior is the best assurance for the safety of patients and staff.
   a. becoming better
   b. becoming worse
   c. staying about the same

7. The “least restrictive alternative doctrine” requires that the least invasive methods be used to control violent patients.
   a. involving a person’s privacy or rights as little as possible
   b. as painful as possible
   c. making the smallest incision

8. When talking to the patient (verbal de-escalation), the overriding principle is that staff convey their professional concern for the well-being of the patient, that the staff is in control, and that no harm come to the patient.
   a. the lowest priority
   b. the highest priority
   c. a mid-level priority

9. Never minimize or “write off” patient threats or feelings.
   a. take something very seriously
   b. dismiss something as unimportant
   c. include this information in a chart

10. It is crucial that staff be consistent in their approach because manipulative patients may attempt to split staff who do not have a unified strategy.
   a. cause team members to work against each other
   b. make people work more than one shift
   c. change staff’s assignments to patients