Violence and Aggression in the Hospital Setting

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Transition to Clerkship

September 4, 2013

Overview

- Prevalence
- Risk factors
- Stages of violence
- Management
- Medico-legal issues
- Response to Assault

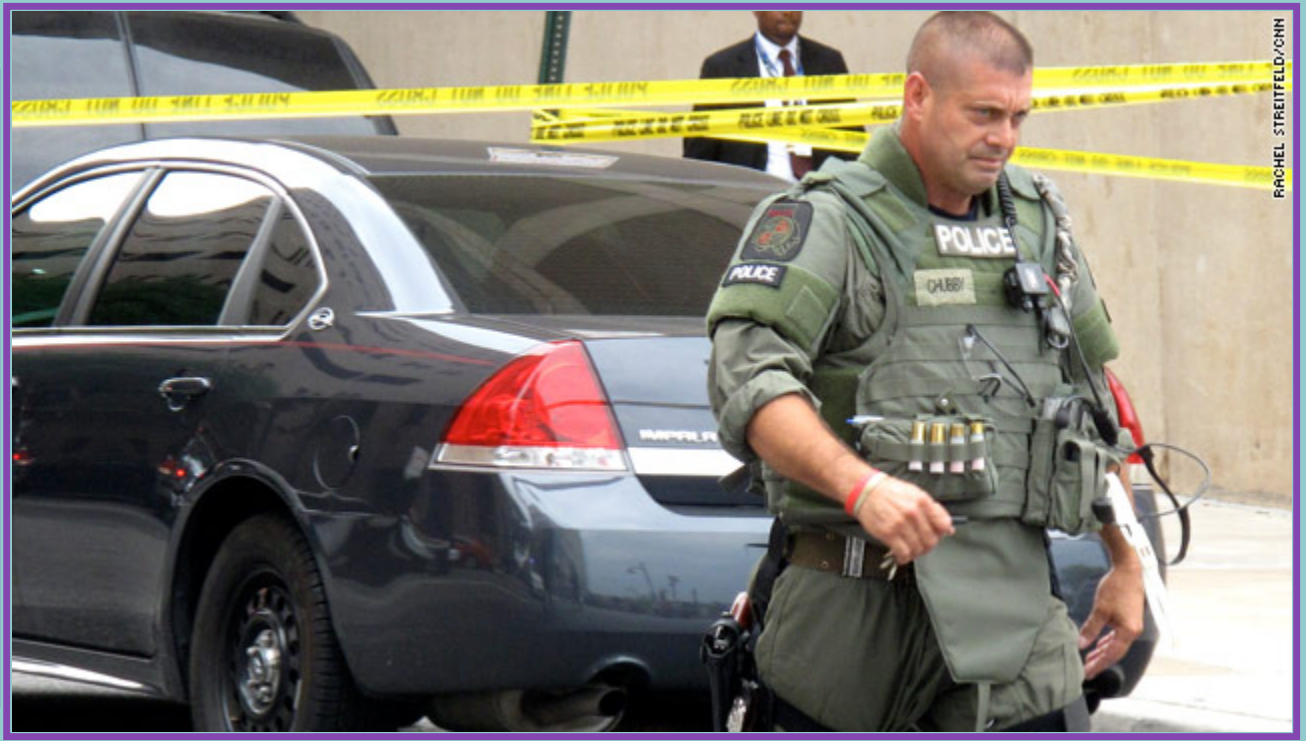
Man kills mother, self at Baltimore hospital after wounding doctor

By the CNN Wire Staff
September 16, 2010 6:29 p.m. EDT

Police: Gunman shoots self, mother

STORY HIGHLIGHTS

- **Police say shooting at prestigious Johns Hopkins was a murder-suicide**
- **The gunman wounded a doctor before turning the gun on his mother and himself**
- **The man became "emotionally distraught" after hearing bad news, commissioner says**



The Medical Post

Volume 36 No. 3 $62.50 per year | The Rogers Media newspaper for the Canadian medical profession | Toronto, January 18, 2000

Media-Publishing, 777 Bay Street, Toronto, Ont. M5W 1A7 Canada Post – Canadian Publications Mail Sales Product Agreement No. 222739.

Violence now part of ER life

By PIPPA WYSONG

TORONTO – With shootings, stabbings and verbal abuse, ERs across the country have turned into war zones.

Some blame it on what is believed to be a rise in "triage rage," with blame being directed toward cutbacks and ER staff shortages. Others say it's just the nature of the job.

On New Year's Eve, the hostage taking of a Toronto doctor in an emergency department resulted in a call to the police, who shot and killed a 26-year-old man who was holding a pellet gun to the back of a doctor. The man was apparently upset because staff wouldn't give immediate care to his daughter.

Only weeks earlier, two similar incidences happened in ERs in Vancouver. One occurred in a Langley hospital in which police shot a 46-year-old patient in the

see ER VIOLENCE / Page 2

ER violence

Longer waits are leaving staff helpless and fatigued, while patients get frustrated

AGITATION IN THE ED'S

- ED prone to violence- 10% of psychiatric emergencies *(Huff et al, BMJ 2007)*
- US: ~1.7 million psychiatric emergency visits/yr involving agitation of 3.4 million visits
  - 21% (900,000) agitated with schizophrenia
  - 13/% BAD (560,000)
  - 5% dementia (210,000)

(Allen et al, Gen Hosp Psych 2004)

- 2008 National Emergency Department Safety Study
  - > 25% ED staff felt safe at work: 'sometimes', 'rarely', 'never'

(Kansagra et al, Acad Emerg Med, 2008)

- 2010 Emergency Nurses Association
  - >50% ED RNs verbally/physically threatened within past 7 days

- 1999 Fernandes, CJP: St. Paul's Hosp. Vanc. (n=106)
  - 90% verbal abuse > 1/wk
  - >20% px'ly threatened
  - >50% px'ly assaulted
  - Highest risk: RN's, security

6 x as many RN's assaulted
cf MD's

Violence against Health Care Workers: The Scope of the Problem

- 40% of psychiatrists and 40-50% of psychiatric residents assaulted at least once

  (AMA Young Physicians Section, 1995), (Chaimowitz et al, 1991)
- 41% of internal medicine residents assaulted at least once

  (Pane et al, 1991), (van Imeveld et al, 1996)
- New Zealand 2001 (Coverdale et al):
  - 64% psychiatry trainees assaulted
  - 29% internal medicine
  - 20% surgery

    N=52; only 1 reported

The University of Toronto Experience: 2001-2002

Email survey of 2001-2002 third year class

- Students asked about assault experiences
- 6/177 (3.4%) reported physical assault
- 4/6 on Psychiatry, 2/6 Internal Medicine
- 4/6 reported incident, 3/4 felt better after reporting

Descriptions of assault experiences:

- "She suddenly turned to me and grabbed my neck with both hands".
- "She screamed that she hated me, hurled herself into me, pushing me into the door frame".
- "He was screaming threats at me and kicking at the glass, the only thing between us was an unlocked door I was leaning against".

The University of Toronto Experience: 2001-2002

- **Recommendations:**
  1. Need for formal reporting system
  2. Need for debriefing/ support services to be in place for students
  3. Better communication to students by staff about potentially violent patients

(Waddell et al, 2005)

Risk Factors for Violence

I. The Setting

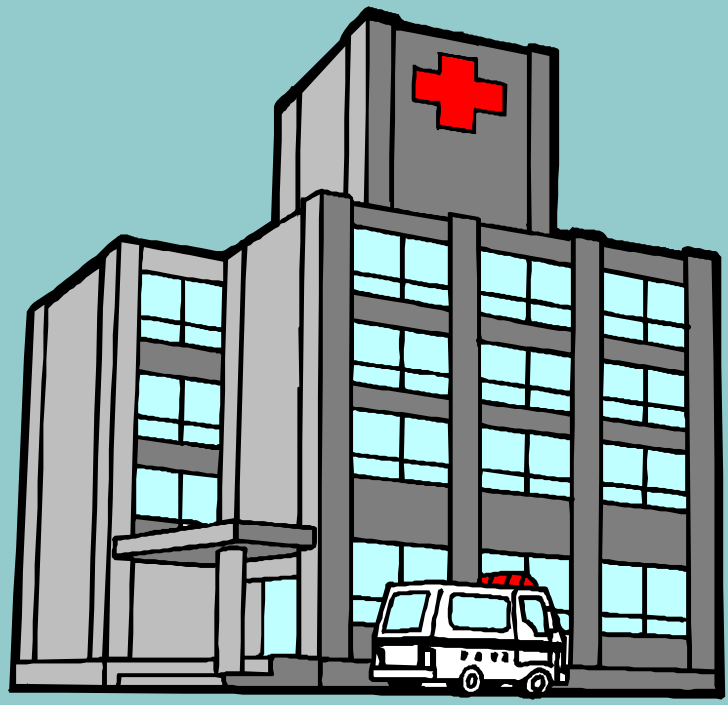
- Emergency Department
- Psychiatry Unit
- Units with high rates of cognitively impaired patients

(AMA Young Physicians Section, 1995)

Risk Factors for Violence

The Setting – e.g. ER

- long waiting times
- unpleasant environment
  - uncomfortable seating
  - lack of distraction
  - noise and commotion
  - lack of access to refreshments
- poor patient-family-staff communication
- lack of updating information
- lack of understanding of triage
- provocation by fatigued and overworked staff



(adapted from Pane et al, 1991; Lavoie et al, 1988)

Elements that Increase Patients' Anger & Could Provoke Low-Level Violence

- Delivering information in a way that causes anxiety to the patient
- Reassuring poorly
- Dragging things out
- Revealing too little
- Ignoring the patient's pocketbook
- Ordering too many tests
- Forgetting to treat pain

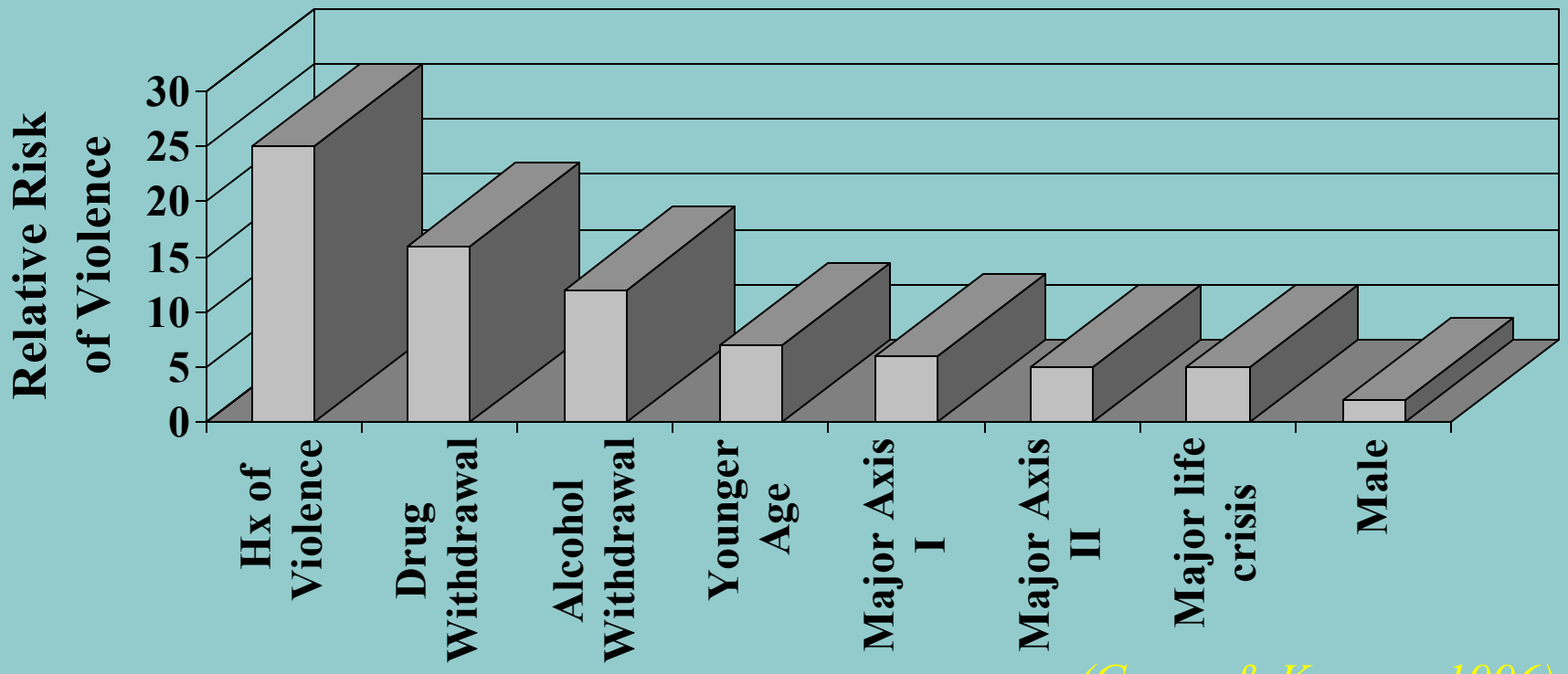
Adapted from Oppenheim MD: Seven ways doctors torture their patients. Hippocrates 10:61-65, 1996. (http://www.medscape.com)

(Felton, 1997)

Risk Factors for Violence

II. The Perpetrator

- 80% patient, 20% friend/family

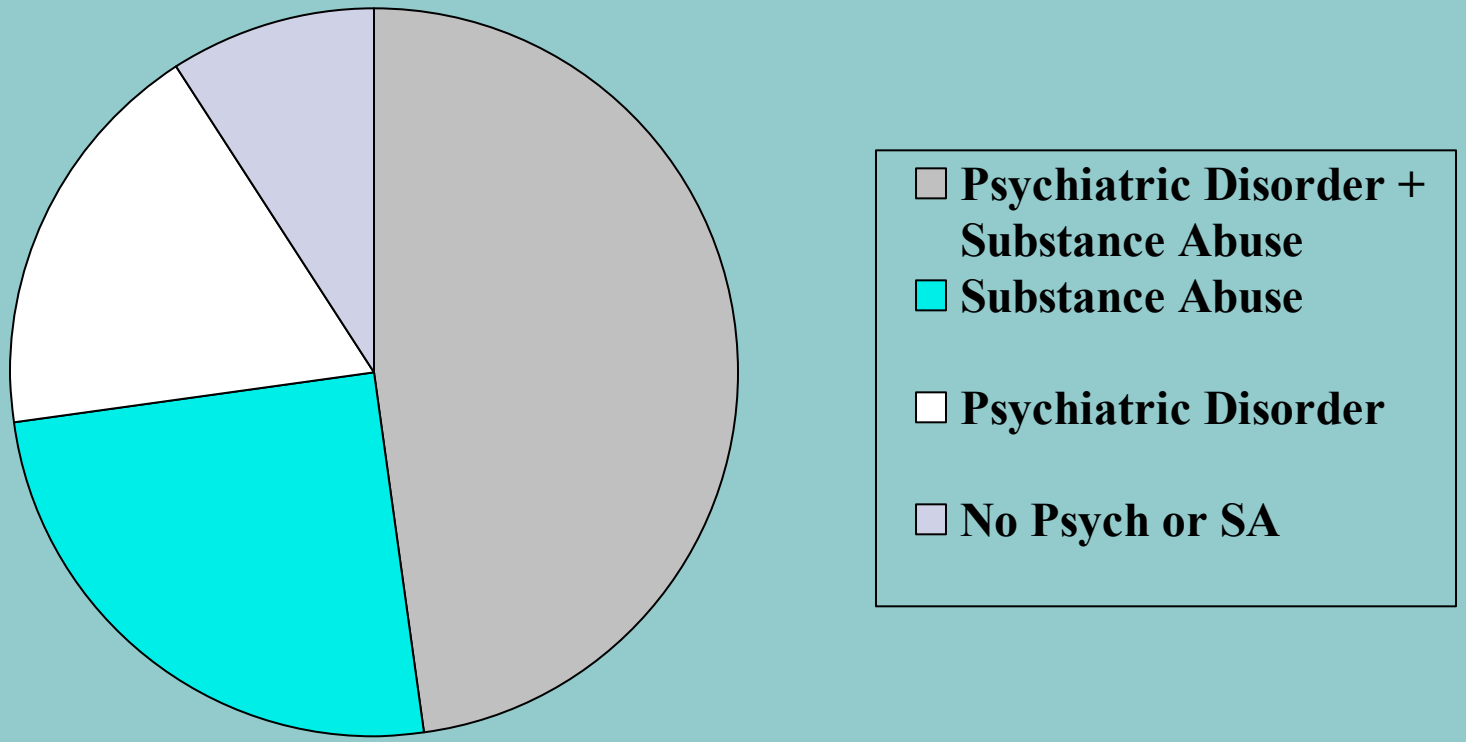


(Gregg & Krause, 1996)

Risk Factors for Violence

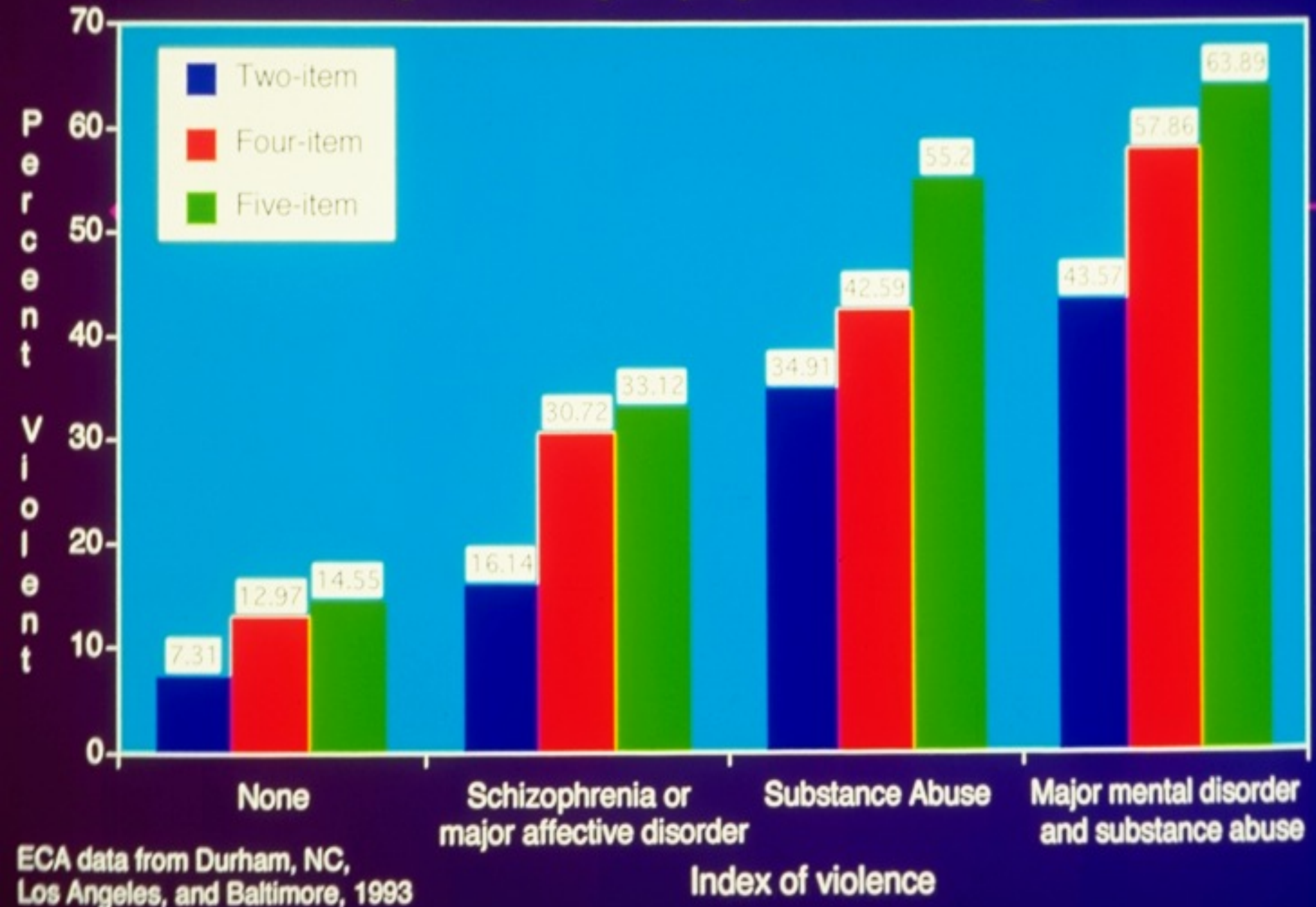
II. The Perpetrator

- characteristics of ‘high risk’ patients



(Drummond et al, 1989)

Current-year major psychiatric diagnosis



ECA data from Durham, NC, Los Angeles, and Baltimore, 1993

Risk Factors for Violence

Psychopathology

Organic

- substance related*- EtOH, stimulants, hallucinogens
- 2º GMC- dementia, delirium, TLE, HI, MR

Psychotic

- mania, schizophrenia

Nonpsychotic nonorganic

- ASPD, BPD
- 'gang membership', forensic hx

(Tardiff, Arch Gen Psych, 49:493-499, 1992)

Substance Related

INTOXICATION

stimulants, hallucinogenics, PCP, MDMA (E)
cannabis, EtOH, inhalants, club drugs
(K, GHB, Rohypnol)

WITHDRAWAL

alcohol, benzodiazepines, narcotics

Risk Factors for Violence

III. The Victims

- nursing staff
- security
- gender of staff not consistently significant
- amongst physicians:
  - Psychiatrists
  - Emergency Physicians
  - Urologists
  - Gastroenterologists
  - Geriatric Caregivers
  - Gynaecologists (abortions)
  - Substance Abuse Caregivers

Stages of Violence

Stage I: Agitation

Stage II: Escalation/Verbal Threats

Stage III: Overt Aggression

Stage IV: Resolution

Stages of Violence

Stage I: Agitation

affect: nervous, frustrated, angry, suspicious

behaviour: pacing, restless, (withdrawn), wrist-wringing

speech: increased volume, rate, demanding, critical, profane

Stages of Violence

Stage II: Escalation/Verbal Threats

appearance/affect: face,	clenched jaw, "white knuckling", flushed glaring, sweating
behaviour:	increased pacing, gesturing, pointing, menacing, invasion of space
speech:	loud, swearing, threatening, demanding

Stages of Violence

Stage III: Overt Aggression

- Damaging Property
- Kicking
- Pushing
- Biting
- Grabbing
- Blunt Trauma with Object
- Spitting
- Choking
- Projectile
- Stabbing
- Punching
- Shooting

(Yassi, 1994)

Management

Prevention

1° Prevention: reduce likelihood of violence

2° Prevention: prevent escalation

3° Prevention: prevent further violence, injury to persons

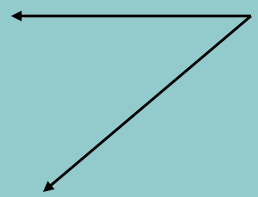
Management

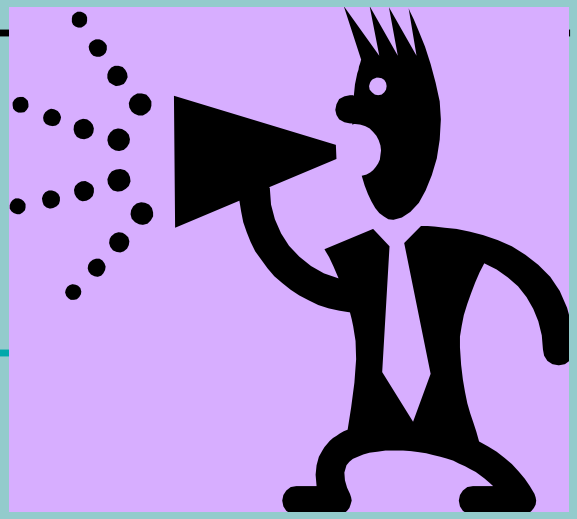
Stages of Intervention

1. Safety
2. Verbal De-escalation
3. Physical Interventions
4. Medication
   - mild agitation
   - severe agitation

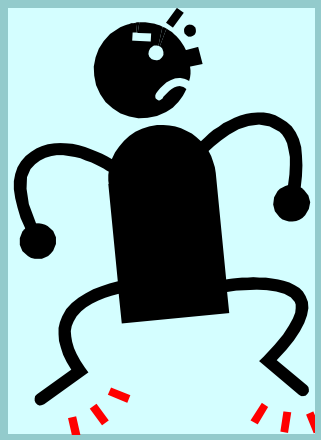
Stages of Violence

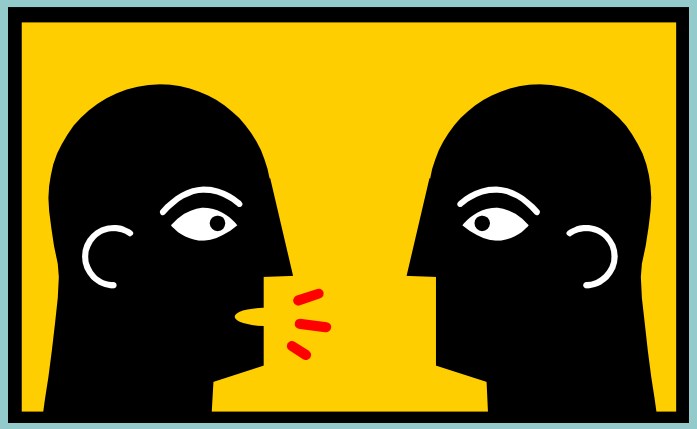
1. Anxiety/Agitation
2. Verbal Threats
3. Overt Aggression
4. Resolution





Management:
Non-Pharmacologic





Stage I
Agitation →Safety

Safety: door ajar, open routes
staff available/present
personal space: 3-4 feet

Body Language/ Speech: respectful, empathic
avoid aggressive stance
calm, non-judgmental

Intervention: listening attentively
problem solving, explanation/limit setting,

Safety

- quiet room with 2 doors- 1 ajar
- equidistant to patient and door
- “buffer zone” 4 x normal
- prearranged alarm signal
- objects as weapons
- fashion as weapons
- extra staff prn

Stage II
Verbal threats →Verbal de-escalation

Safety:	personal space 6 feet
	remove bystanders, staff present
objects as weapons	
Body Language/ Speech	non-threatening posture
	calm, in control, clear instructions, choices
	don't argue or interrupt excessively
Intervention:	support internal locus of control, limit setting, offer choices, Code White

Stage III
Overt Aggression

Safety:	clear area
	Code White team assembled
Body Language/	defensive posture
Speech:	minimal communication: simple, clear repetitions
Intervention:	mechanical restraint, chemical restraint,
	personal safety techniques
	Police

Physical Interventions

Anticipate assault

- punches
- grabbing
- choking
- biting
- weapon (knife, gun)

Mechanical restraint prior to chemical…

Code White

Code White

is activated when someone represents a threat to the safety, well being or security to themselves, other patients, visitors or staff

Code White Response Team

- Psychiatric Nurse/Nursing Supervisor
- Psychiatric Assistant
- Security Officer
- Responsible Physician (if patient involved)

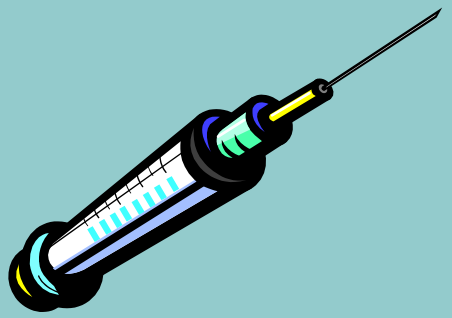
Code White: Response to Violent Person

- Dial 5555
- Request Code White
- Provide info to switchboard: repeat x 2
  - name
  - weapon
  - location
  - hostage taken?
- If with pt, direct other staff to call and notify MD in charge *[if violent person is a pt]*
- Monitor, assess, support violent pt until team arrives

Code White

- Post-event debriefing
  - Team leader leads review
  - Consideration for need of further counseling
- Post-event documentation
  - Within 24 hrs
  - Site-specific forms

Management:
Pharmacologic



Medication: Mild Agitation

NON-PSYCHOTIC

- **Lorazepam**
  1-2 mg po/sl

- **Clonazepam**
  0.5- 2.0 mg po

PSYCHOTIC

- **Lorazepam 2 mg po/sl**

  or

  Olanzapine diss. {*Zydis*}
  5-10 mg

  or

  Risperidone diss. {*M tab*}
  2 mg

  or

  Loxapine 25 mg po +/-
  Lorazepam 2 mg sl

[Quetiapine NOT in ED- orthostatic hypotension]

Medication: *Severe Agitation*

NON-PSYCHOTIC

- **Lorazepam 2-4 mg IM**
- **Diazepam 5-10 mg IV**

PSYCHOTIC

- **Haloperidol 5-10 mg & > IM Lorazepam 2-4 mg**
- **Loxapine 12.5-25 mg IM**
- **Olanzapine 10 mg IM**

Prevention

- alert to angry patients
- see irritated patients when staff available
- plan for receptionist
- dress with safety in mind
- alarm buzzers, video surveillance
- awareness of counter-reactions

Medico-Legal Issues

- Form 1/42
- Duty to Warn
  - victim(s)
  - police
- Document
- Forensic Consultation

Reasons for underreporting

- fear of being blamed
- assault would reflect negatively on competence
- denial
- feeling a cause of the incident

Response to Assault

Initially:

- Denial: "no big deal"
- Rationalization: "part of the job"
  "the patient is ill"
- Minimization:

"he only lunged at me, he didn't actually hit me"
"the telephone hit the wall when she threw it, not me"

Reactions in the short term

- anxiety regarding taking call
- avoidance of the ER/ward where assault occurred
- emotional unavailability or displacement of fear/anger towards patients with similar diagnoses or characteristics
- counterphobic response - take lots of call, interview potentially dangerous patients without proper backup, downplay need for PA(s)

Delayed Reactions

- excessive anxiety apparently unwarranted when in same setting or with similar patient
- may occur months later

Variants of PTSD
(immediate or delayed onset)

Acute Stress Disorder (DSM IV)

- duration: 2 days to 4 weeks
- within 4 weeks of stressor
- dissociative symptoms

Both ASD & PTSD

Re-experience

- recurrent intrusive thoughts of event
- disrupted sleep - dreams, nightmares
- distress at re-exposure to similar situations, anniversaries (e.g., taking call on a similar day)
- Flashbacks

Heightened Arousal

- sleep disruption
- anger/irritability
- hypervigilance
- increased startle response

Avoidance

- stimuli that arouse recollections of the trauma: call, similar pts

What to do

- talk - to supervisors, colleagues, ER staff, treatment team
- compare your experience to those of others - feel less alone
- behavioral techniques
  - exposure to similar patients and setting
  - expect to be anxious but acknowledge that this will pass
- report as an incident, consider laying charges

Protocol For Responding To Assault: In Development

1. Informal immediate debriefing provided by code white team leader or resident/staff involved.

2. Fill out hospital Employee Incident Report.

3. Site Course Coordinator should be notified.
   - Refer to occupational health, if necessary.
   - Remove student from service if ongoing danger.
   - Provide faculty support contact list.
   - Provide contact with peer support services.

4. Inform Academy Director that incident has occurredAcademy Director
   - Student incident report filled out (name optional).
   - Ensure student is aware of support services.
   - Provide hospitals and faculty with data about assaults.
   - Encourage CPI training for any interested students.