From De-escalation to Self-Defense

What to do when a patient or visitor turns violent

In November 2014, a viral video distributed via news and social media channels sent shock waves throughout the health care community. The disturbing footage showed a rampaging hospital patient attacking four nurses with a metal pole.[1] The nurses survived but sustained several injuries; the patient, meanwhile, was tasered, tackled, and handcuffed.[1]

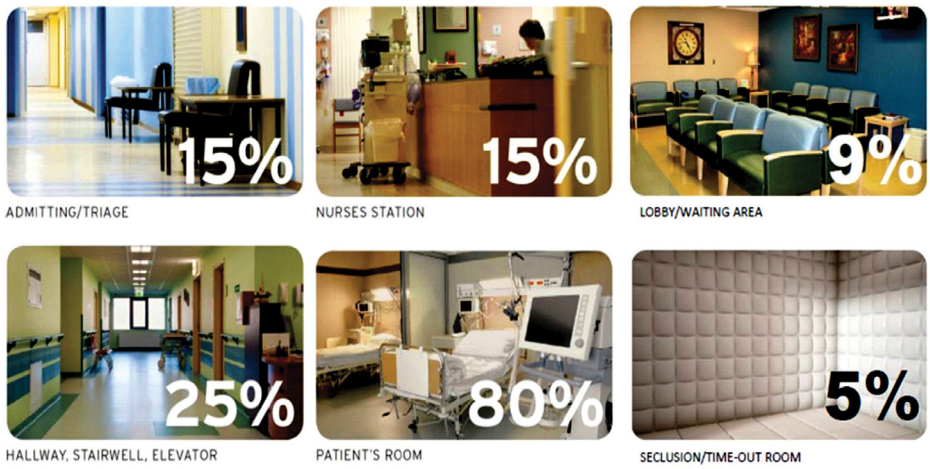
If you've watched the news lately, you've seen increased reporting of violent patient activity like this in medical facilities. In fact, more than 2,300 incidents involving serious threats or acts of violence occurred in health care environments between January 2012 and July 2014, with many more attacks going unreported, per the International Committee of the Red Cross (ICRC).[2]

According to the results of the 2011 Emergency Department Violence Surveillance Study conducted by the Emergency Nurses Association (ENA), five commonly reported factors precipitate incidents of workplace violence in the emergency department (ED)—a common site for such events (*see* Physical Violence Incidents by Location," above). These are the five factors:

1. Caring for psychiatric patients in the ED (89.4%)
2. Drug-seeking behavior by patients/visitors (87.9%)
3. Patients/visitors under the influence of alcohol (80.4%)
4. ED overcrowding (79.9%)
5. Patients/visitors under the influence of illicit drugs (77.1%)[3]

In its January 2015 article "Code Black and Blue," *EC News* examined why patients turn violent, how to recognize the warning signs, and how to prevent aggressive incidents via training, education, and reporting. This article continues exploring the topic, discussing ways to respond quickly and effectively to a violent patient or visitor.

Physical Violence Incidents by Location



Source: HSS Inc.

On alert for orange

In recent years, Cooley Dickinson Hospital in Northampton, Massachusetts, has seen its share of violent patient/visitor events, which it calls "code oranges." In fact, the facility experienced 75 of them in the fourth quarter of 2014 alone, along with 96 "standby" occurrences of lesser severity. When a code orange alert is issued, specially trained staff and security are immediately summoned to the area.

The frequency of code orange alerts at Cooley Dickinson has gradually increased over the past five years—likely due to staff being more alert and eager to report incidents. But the good news is that, in January 2015, events requiring the use of physical restraint on patients—often a measure of last resort that can cause more harm than good—decreased 50% at the hospital. So reports Cooley Dickinson's patient safety and regulatory compliance manager, Shannon Dillard.

"It happens at every hospital, and here is no exception. We've had patients throw punches, spit on workers, and even hurl furniture [*see* "Most Common Types of Physical Violence in the ED," page 8], resulting in significant enough injuries that some staff have been out of work for at least a short period of time," says Dillard. She also notes that the goal of calling a code orange alert is to keep both staff and patients safe and avoid use of restraint.

"Although the vast majority of our code oranges don't result in injury, they are still tough on our staff, who are already challenged with trying to deliver good care," she says. "It's important for our workers to feel safe in their jobs."

To help workers feel safe, Cooley Dickinson provides violence prevention training to all ED and behavioral staff and other key employees. The hospital also conducts code orange debriefings with affected workers soon after an event as well as safety huddles each morning, during which department leaders review past code oranges and forecast future incidents.

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"We're more successful at keeping staff and patients safe if they learn the proper techniques for responding to a code orange, including verbal de-escalation and, if necessary, takedown of the patient," Dillard says.

Words speak louder than actions

Jeff Puttkammer, director of learning and development for HSS, Inc., a Denver-based health care security provider, says it's crucial that health care workers know how to respond when a patient or visitor turns hostile verbally and/or physically. (*See* "Key Training Components: P.O.W.E.R." at right.)

The initial goal is to focus on verbal de-escalation with the person. A successful tactic to accomplish this is to be collaborative by using *we* statements and open-ended questions, such as "We are here to help you," "Tell us what you're feeling," and "How can we help you?"

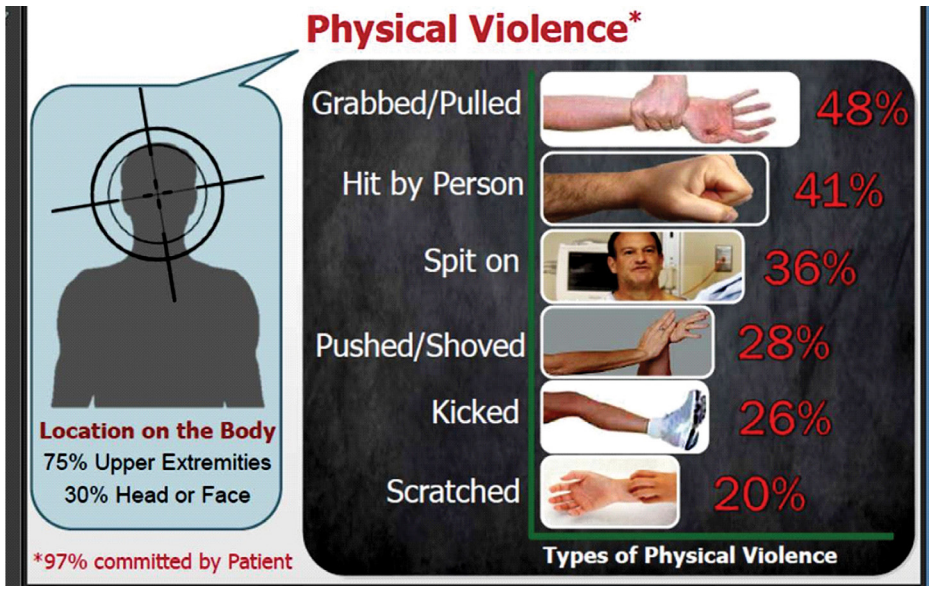
"Pay close attention to the words you're hearing and the words you're speaking. A breakdown in communication and understanding often contributes to continued escalation," says Puttkammer. "Provide verbal encouragement and focus on behavior. Don't ignore the problem. Instead, be proactive and address the patient's concerns."

If the patient escalates further, move to *I* words, like "Your behavior is unacceptable. I need you to remain in your bed." Maintain eye contact but don't stare down the patient; use reassuring, not condescending, language; and respect the patient's personal space.

On the latter point, "it's wise to keep a fair and safe distance between you and the agitated individual—at least 6 feet is ideal, preferably with you standing in the doorway so that you have a quick escape route if necessary," Puttkammer notes. If you're already in the room, don't allow yourself to become trapped in a corner; try to keep a barrier (such as a bed) between you and the patient and determine if there are any hazards present in the room that you can remove, such as an object that can be used as a weapon against you.

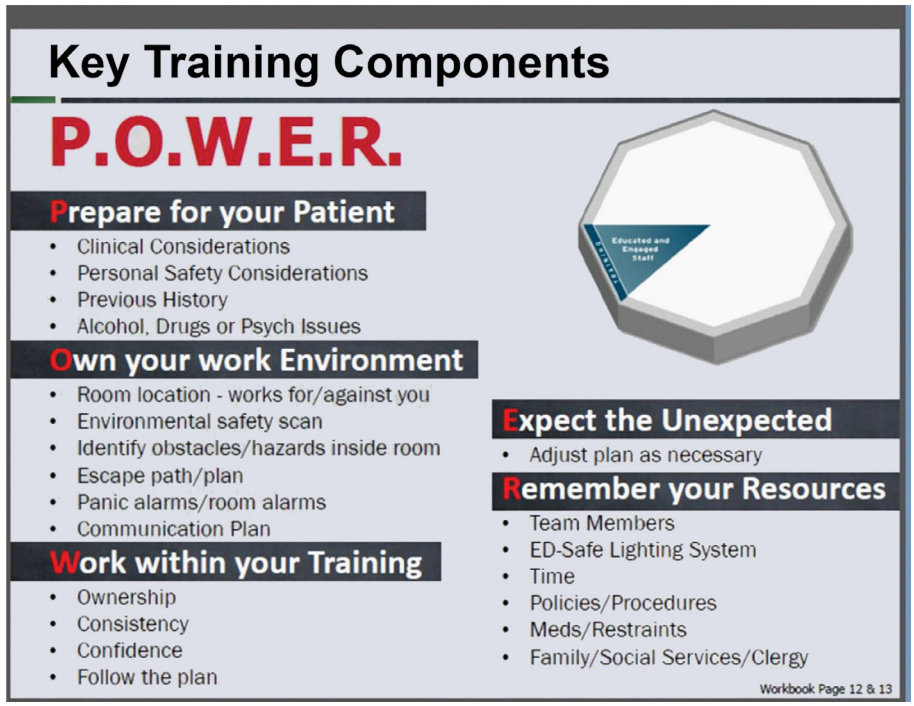
If these steps fail to defuse the person, Puttkammer says it's time for you to leave the room or area and summon additional help and resources. If the patient attacks, try to deflect the attack and disengage from the attacker, aiming for a defensive/protective reaction rather than

Most Common Types of Physical Violence in the ED



Source: HSS Inc.

Key Training Components: P.O.W.E.R.



Source: HSS Inc.

Aggression Suppression

The National Institute for Occupational Safety and Health (NIOSH) suggests the following tips to help manage a violent patient event:

- **Maintain behavior that helps defuse anger:**
  - Present a calm, caring attitude.
  - Don't match the threats or give orders.
  - Acknowledge the person's feelings (for instance, "I know you are frustrated").
  - Avoid any behavior that may be interpreted as aggressive (for example, getting too close, moving rapidly, speaking loudly, or touching).
- **Be alert:**
  - Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
  - Be vigilant throughout the encounter.
  - Don't isolate yourself with a potentially violent person.
  - Always keep an open path for exiting; don't let the potentially violent person get between you and the door.
- **Take these measures if you can't quickly resolve the situation:**
  - Remove yourself from the situation.
  - Call security for help.
  - Report any violent incidents to your management.

Source: Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. Violence Occupational Hazards in Hospitals. DHHS (NIOSH) Publication Number 2002-101. April 2002. Accessed Feb 2, 2015. http://www.cdc.gov/niosh/docs/2002-101/default.html.

Anti-Violence Measures from The Joint Commission

The following are among the actions that The Joint Commission suggest health care organizations can take to prevent patient violence:

- Work with security personnel to audit your facility's risk of violence.
- Identify weaknesses and strengths and make improvements to your violence-prevention program.
- Take extra security precautions in the emergency department.
- Require appropriate staff members to receive violence prevention training.
- Encourage staff to report incidents of violent activity and any perceived threats of violence.
- Provide counseling services for staff who experience patient violence.
- Review each event and make changes to prevent future occurrences.
- Ensure that applicable Joint Commission standards are implemented, including EC.01.01.01, "the hospital plans activities to minimize risks in the environment of care"; EC.02.01.01, "the hospital manages safety and security risks"; and EM.02.02.05, "as part of its emergency operations plan, the hospital prepares for how it will manage security and safety during an emergency."

Source: The Joint Commission. Preventing violence in the health care setting. *Sentinel Event Alert* 45, Jun 3, 2010. Available at: http://www.jointcommission.org/assets/1/18/SEA_45.PDF. Accessed Feb 2, 2015.

an aggressive counteraction that could harm you both.

For instance, "If the patient is trying to swing at you with an IV pole," says Puttkammer, "we advocate blocking the attack and attempting to remove the object from the attacker if you can. This technique can be learned through proper violence prevention training."

In addition, health care organizations should also follow recommendations from the National Institute for Occupational Safety and Health (NIOSH) and The Joint Commission for managing and preventing violent patient events (*see* "Aggression Suppression," left, and "Anti-Violence Measures from The Joint Commission," above).

Attack plan

Tony York, chief operating officer for HSS and author of a volume on hospital and health care security, says it's important to have a plan for an effective and quick response to patient violence. "Not enough health care organizations create such a plan," notes York. "Doing so should be a top priority, as it can decrease injuries, liabilities, workers' compensation claims, and staff turnover."

This violence prevention and response plan should include:

- Initiating a violence prevention and management training program that staff and physicians are required to complete
- Completing an analysis to identify your organization's areas of weakness and risk for violence. This analysis could be part of your formal hazard vulnerability analysis (HVA), required by The Joint Commission
- Evaluating and, if necessary, revising your Emergency Operations Plan (EOP)
- Ensuring better coordination and communication between security personnel and clinical staff and a clearer understanding of the duties and responsibilities of each during a violent event
- Implementing necessary environmental controls, possibly including many of those most commonly used in the ED, per the 2011 ENA study:
  - Making sure areas are well lit (indicated by 91.5% of survey respondents)
  - Providing physical/leather restraints (88.2%)
  - Strategically placing security cameras (86.1%)
  - Providing locked/coded ED entries (81.9%)

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- Choosing a pseudonym to call a code to alert other staff to a situation (77.8%)
- Providing chemical restraints
- Using a panic button/silent alarm (74.7%)[3]

It's also imperative to evaluate your violence prevention and management strategy and its components regularly to gauge effectiveness and bolster weak areas.

"Many organizations I visit and talk with provide programs, but they don't have good training or acceptable compliance rates," says York. "Violent events are often underreported because the organization has a culture of tolerance or is more focused on patient safety than staff safety, when both should be equally emphasized."

To avoid these problems, York says "there has to be buy-in from top leadership, established protocol that is practiced and enforced, and an honest assessment of what is and isn't working to create safe outcomes for patients and workers alike." EC

References

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