Dealing with Assaultive Behavior: An Overview for CNAs

Five (5.0) Contact Hours

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Course Expires: March 14, 2018

First Published: March 14, 2014

Acknowledgments

RN.com acknowledges the valuable contributions of...

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**Purpose**
The purpose of this course is to provide CNAs with information that will assist them with dealing with aggressive or disruptive patients in the healthcare setting.

**Learning Objectives**
*After successful completion of this course, you will be able to:*
1. Identify characteristics of aggressive and violent behavior in patients.
2. Describe the concept of violence.
3. Describe factors that may lead to aggression and violence.
4. Discuss general safety principles.
5. Describe techniques and strategies to avoid physical harm.
6. Describe resources available for coping with violence.
7. Identify types of restraints and restraining techniques.
8. Describe ways to prevent workplace violence.

*Whenever there is any interaction between healthcare workers and patients, and their families and friends, there is a potential for violence.*

**Introduction**
Certified Nursing Assistants (CNAs) and nursing home staff often encounter physical and emotional violence from patients, residents or family members.

The Bureau of Labor Statistics found that certified nurse assistants (CNAs) in nursing homes are at highest risk for workplace assault (Fitzwater & Gates, 2002).

Behavior toward staff that results in physical or emotional attacks by residents can be described as aggressive and disruptive behavior.

Some CNAs who experience this type of behavior from residents perceive these acts as “violence in their workplace” (Fitzwater & Gates, 2002).

Violence in the workplace results from a variety of internal and external causes and may affect us in a multitude of ways.

**Violence in the Healthcare Setting**
Violence can occur in any culture and affect any socio-economic group of individuals. The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as “violent acts (including physical assaults) directed toward persons at work or on duty.”

In the workplace, violence can be interpreted as offensive language, behavior that is threatening, threats of physical assault, and homicide (Abrella, 2005).

Violence is an outpouring of strong emotion that can result in danger for the victim and the aggressor.

Any employees that might be exposed to aggressive behavior, threats, and threats of physical harm in the workplace should be provided with training so that they can protect themselves and others. To respond quickly and effectively to an outburst of assaultive behavior, staff will require appropriate
Violence can be defined as a harmful and out of control outburst of emotions and actions used to try to achieve a desired goal.

**What Is Aggressive Behavior?**
Aggressive behavior is behavior that causes or threatens to cause physical or emotional harm to other. It can range from verbal abuse to the destruction of a victim’s personal property.

Aggressive behavior is intentional, meaning it’s done on purpose, and causes a breakdown in a relationship. Emotional problems are the most common cause of aggressive behavior (Gabbey, 2013).

Occasional outbursts of aggression are common and even normal. Aggressive behavior becomes a problem when it occurs frequently or in a pattern. Generally speaking, aggressive behavior stems from an inability to control behavior, or from a misunderstanding of what behaviors are appropriate (Gabbey, 2013).

Aggressive behavior can be reactive (in response to something). It can also be proactive, as an attempt to provoke a victim. It can be either overt (easy to see) or secretive.

Aggressive behavior can also be self-directed. People with aggressive behavior tend to be irritable, impulsive, and restless.

*The key to handling aggressive behavior is to understand what the cause is.*

**What Causes Assaultive Behavior?**
The causes of assaultive behavior are often related to disease processes and / or behavioral causes.

Patients with dementia or late-stage Alzheimer's disease may act aggressively for no apparent reason. No-ones knows for sure if this is a symptom of the disease itself or a reaction to the actions of others or to the environment of the patient. The CNA should always treat all patients with dignity and respect. This will minimize the chances of aggressive behavior.

Some researchers believe that assaultive behavior is caused by factors in the environment. Some scientists think that a lot of violent people model their behavior on the behavior they see in others. For example, a child who sees his or her parents behaving in an aggressive and violent manner will often become a violent and aggressive adult.

Other scientists believe that people who are socially isolated and do not have strong emotional ties with others are more likely to become aggressive or violent (CDC, 2009).

**Risk Factors For Assaultive Behavior**
Although it is very difficult to predict which patients may become aggressive, there are certain risk factors that can increase the possibility of aggressive or violent behavior.

These risk factors may include:

**Individual factors:**
- Prior history of aggression and abuse
• Substance abuse (alcohol, drugs)
• Impulsiveness
• Low educational level

Relationship factors with peers or within family environments:
• Lack of parental supervision
• Harsh parenting practices
• Association with others involved in delinquent activities

Additional Risk Factors for Assaultive Behavior
Community factors:
• Unemployment
• Lack of a permanent home
• Dense population
• Drug trafficking
• Social isolation
• Little institutional supports

Society factors:
• Cultures that support violence as an acceptable way to resolve conflicts
• Cultures that give priority to parental rights over child welfare
• Cultures that support male dominance over women and children
• High levels of economic or social inequality within groups or countries
• Unequal educational opportunity
• Lack of access to healthcare

The Need for Assaultive Behavior Training
Since CNAs work so closely with all types of people, it is important for CNAs to be able to recognize early warning signs of potential assaultive behavior in residents or patients, so that action can be taken to de-escalate (decrease or prevent) an outburst or attack.

Without appropriate training, attempting to manage assaultive behavior can be very dangerous for everyone involved. An employee without assaultive behavior training may present an increased risk to themselves and their employer.

Identifying Patients At Risk For Aggression
The CNA is an important member of the healthcare team and can play an important role in recognizing early warning signs of impending aggression in a patient, and reporting it promptly to the Registered Nurse or supervisor.

By proactively (in advance) observing patients for early signs of frustration or anger, the CNA can possibly prevent a situation getting out of control.

Possible warning signs that may alert you to the possibility of impending aggression may include:

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• The presence of a weapon in the patient's possession
• A past history of dangerous or impulsive and aggressive behavior
• A patient who verbalizes his or her intent to harm others
• Substance abuse (drugs and / or alcohol)
• Recent intense stress
• Lack of family or social support

**The Physical Environment**
CNAs should learn about the effects of their surrounding physical environment; how a lack of privacy, limited access to bathrooms and a how a climate that is very hot or very cold can lower an individual’s threshold for frustration and anger (DHHS, 2005).

The physical environment should take into consideration the need for:
• Privacy
• Safety (including alarms)
• Gender
• Physical space
• Social and religious expression
• Cleanliness

**Alcohol**
A patient experiencing the initial symptoms of alcohol withdrawal may become increasingly agitated or violent.

Small amounts of alcohol (reflected in blood alcohol concentrations) usually produce lowered inhibitions, increased self-confidence, reduced attention span, decreased judgment and slight lack of co-ordination.

Higher levels of blood alcohol can cause aggression and alterations in mood (Boggan, 2003). Of all psychoactive substances, (any substance that results in a temporary change in behavior, mood or perception) alcohol has been shown to increase aggression the most (Roth, 1994).

**Drugs and Violence**
Research indicates that there are strong correlations between violence and psycho-active substances such as drugs, illegal substances, and alcohol.

The overall effects of drugs will depend on the type of drug. Some individuals may experience violent outbursts of behavior after using large doses of street drugs such as cocaine, amphetamines, PCP, and LSD.

**Violence and Mental Health**
Although Patients with a history of mental illness may also be at risk for being aggressive, studies have shown that individuals with a major mental illness are much more likely to be the victim of violence than other members of society (The Canadian Mental Health Association, 2007).

*Do not assume that all patients with mental health disorders have an increased potential for*
aggressive or violent behavior. Recent studies have shown that alcohol and substance abuse contribute to acts of violence far more than a diagnosis of mental illness.

According to the United States Department of Health and Human Services Substance Abuse and Mental Health Services (SAMHSA), the overall likelihood of violence is low in individuals diagnosed with mental illness. Yet, people who have been diagnosed with severe psychosis could pose a minimal risk for violence especially if they are not taking their prescribed medication.

Violence can be a factor with individuals who have dual diagnoses such as a mental disorder and a substance abuse disorder.

Cultural and Gender Risk Factors
Cultural and ethnic differences should also be considered when identifying your patient’s potential risk factors for violence.

Different cultures interpret body language in different ways. In some cultures, prolonged eye contact may be interpreted as aggressive behavior that might invoke a violent response.

In the past, gender has always been a strong predictor for violence, with men being more violent than women. However, according to the National Institutes of Health (NIH), there is evidence that the ratio of male to female violence is closing by one half (NIH, 2004).

The NIH reports there has been minimal research performed that will help to understand why being male is a risk factor and why females are becoming increasingly more violent.

Risk Factors for Adolescents
Research indicates that some groups of youth are more vulnerable to become victims or perpetrators of violence than others, such as males from minority groups.

Although many risk factors for youth violence are the same for all the groups, violence that occurs during childhood and adolescence carries through into the adult years.

The following list of risk factors can contribute to violent or aggressive behavior in youth and is of value when caring for a child or adolescent (CDC, 2012).

Factors include:

**Individual risk factors for youth:**
- Low IQ
- Poor behavioral control
- Attention deficits, hyperactivity, or learning disorders
- Deficits in social cognitive or information-processing abilities
- History of early aggressive behavior
- History of violent victimization
- High emotional distress
- History of treatment for emotional problems
- Involvement with drugs, alcohol, or tobacco
- Antisocial beliefs and attitudes

**Risk Factors for Adolescents**

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Family risk factors for youth:
- Low parental involvement
- Low parental education and income
- Parental substance abuse or criminal activity
- Poor family functioning
- Poor supervision of children
- Authoritarian child-rearing beliefs
- Lax, inconsistent or harsh disciplinary practices
- Low emotional attachment to caregivers/parents

Peer/School risk factors for youth:
- Low commitment to school and school failure
- Social rejection by peers
- Lack of involvement in conventional activities
- Involvement in gangs
- Association with delinquent peers

Community risk factors for youth:
- Large concentrations of poor residents
- High transient level
- High level of family disruption
- Decreased economic opportunities
- Low level of community participation
- Socially disorganized neighborhoods

Risk Factors for Geriatric Patients
Within the geriatric (elderly) population, the causes of assaultive behavior can be grouped into three categories:

- **Patient factors:** Elderly patients with a diagnosis of dementia, organic brain syndrome, or a history of previous assault are most often associated with assaultive behavior.

- **Environmental factors:** Environmental factors that can trigger assaultive behavior include limited body space and excessive environmental stimuli that result in confusion and aggression.

- **Caregiver factors:** CNAs can help to prevent the incidence of assault by recognizing the potential risk factors associated with fear and anxiety in the elderly. An awareness of each patient’s individual needs can help to eliminate patient outbursts of anger, decrease agitation and help in providing a safe and nurturing atmosphere.

Protective Risk Factors
Factors that can reduce the chance of violence are called protective factors. Protective factors help keep an individual in control of their emotions. Strong and supportive ties to family members and significant others can be considered as protective factors.

Risk factors that can lead directly to violent behavior are classified as causal risk factors. Identifying
causal factors that affect an individual may help to predetermine an individual’s response to a stressful situation.

A causal factor may be intrinsic (from within) or extrinsic (external). If the causal risk factor is removed, an individual will be more likely to maintain control and an incident of assaultive behavior may be averted.

**Identifying Risk Factors in the Environment**
The International Council of Nurses (ICN) recognizes that environmental factors can accentuate stress and trigger violence (ICN, 2009). The council suggests:

- Placing security services at main entrances, near visitor's transit routes and in or near emergency departments
- Minimizing access to the facility
- Providing effective lighting
- Providing spacious and quiet reception areas monitored by staff
- Using furniture that can’t be used as a weapon (attach chairs together or bolt to the floor)
- Providing distracting activities while people are waiting (reading materials, television)
- Providing comfortable climate control
- Ensuring communication between staff (cell phones, paging system)
- Installing metal detector screening

![Is this room safe?](image)

No.

The chairs, table and objects in this room can easily become weapons or used as projectiles by a patient whose behavior escalates out of control.

**Managing Assaultive Behavior**
Although there are many approaches to deal with violence and assaultive behavior, recognizing the first signs of frustration that can lead to aggression is important.

A basic understanding of human behavior and knowledge of specific communication techniques will assist CNAs in identifying risk factors that can contribute to violent or assaultive behavior. Because the ultimate goal to manage assaultive behavior is to stop violence before it happens, CNAs must be provided with training, standardized policies and procedures, and a safe working environment.

Admission to a hospital or other healthcare facility can be an extremely stressful time for individuals, their family and friends. Establishing a supportive relationship with patients and their significant others can help minimize misunderstandings and concerns.
Learning how to communicate effectively will help facilitate a therapeutic relationship and a mutual understanding of expectations, desired outcomes and goals while at the facility.

Despite your efforts to provide a non-threatening environment, overwhelming stress, fear, and a loss of control may cause an individual to become aggressive or violent.

**Learning to Communicate Effectively**
As a caregiver, learning to communicate effectively takes practice. It involves the ability to:
- Observe
- Listen
- Respond appropriately

It also means maintaining and practicing an emotional balance and focus while under stress.

When dealing with patients, CNAs must remember that not all patients respond positively to therapeutic touch and can become angry if you touch them or use terms of endearment, such as "honey" or "sweetie-pie" when addressing them.

Consider the following case study:

Jules is a CNA caring for Sheila, a new patient who is non-cooperative and sullen. Jules tries to be nice to Sheila by calling her "sweetie" and using therapeutic touch to calm her down. Observe Sheila's facial expression. Does she seem to appreciate Jule's use of therapeutic touch?

**Answer:**
*Although Jule's use of therapeutic touch might be appropriate with some of the patients he is working with, Sheila's body language clearly indicates she does not want to be touched. CNAs should be very cautious when using therapeutic touch; in most cases a relationship of mutual respect and trust should be developed first.*

**Therapeutic Communication**
CNAs can be instrumental in de-escalating violent behavior and aggression. By practicing therapeutic communication skills, it may be possible to de-escalate a potential violent encounter and restore order for an aggressive patient.

You can facilitate effective communication by making sure to:
- Demonstrate that you hear what is being said
- Speak the individual’s language (talk on their level)

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• Reflect facts and feelings
• Paraphrase and clarify what has been said
• Be sure to ask open ended questions
• Avoid making too many demands on the patient
• Provide brief, easy to understand instructions
• Always tell the patient what you intend to do before beginning any care activity

Demonstrate your concern for an individual by validating that you recognize that they are upset. Statements such as “I can see you are upset” facilitate communication and help the patient calm down as recognition of their feelings is acknowledged.

**Stress**

Stress can be described as an elevated state of readiness and arousal. Initially, stress can initially improve an individual’s performance and help to increase and aid in coping with situations that may seem threatening. A prolonged or too great of an amount of stress will result in a negative effect on the body.

The fight or flight mechanism, also known as the acute stress response, can cause an almost instantaneous increase in heart rate, blood pressure, respiratory rate, metabolism, and a tensing of muscles.

**Social signs of stress include:**
• Difficulty in accepting or giving help or support
• Blaming
• Isolation
• Unable to experience fun

*Imagine that Sheila is your patient and you observe her sitting in her room, as shown in the photo on the left. Based on Sheila’s nonverbal clues, what emotions may she be feeling?*

*Based on body language, Sheila looks as though she could be experiencing grief, depression, confusion, fear, anxiety, memory loss, or inability to concentrate.*

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Behavioral Signs of Stress

Behavioral signs of stress might include:

- Anxiety or fear
- Apathy
- Avoiding certain activities or places associated with stress or negative outcome
- Confusion
- Crying frequently
- Decreased or increased activity
- Denial
- Depression
- Difficulty listening or communicating
- Difficulty making decisions
- Euphoria
- Excessive worry
- Grief
- Guilt
- Inability to concentrate
- Inability to relax and rest
- Increase in absenteeism and decrease in job performance
- Memory loss
- Outbursts of anger, irritability
- Psychological signs of stress
- Substance abuse (drugs or alcohol)

Physical Signs of Stress

Physical signs of stress may include:

- Sleep disturbances and fatigue
- Visual disturbances
- Muscle twitching and tremors
- Chills or sweating
- Aches, pains, and headaches
- Problems with gastrointestinal system

*Stress is only one of many risk factors that can contribute to assaultive behavior and the potential for violence.*

Reasons for Assaultive Behavior

There are four basic senses that can contribute to why an individual may threaten to injure themselves or others: frustration, fear, intimidation, and manipulation.

Frustration

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Frustration is an emotion that can occur when an individual feels that they cannot fulfill or achieve their goals within an allocated time frame. The presence of frustration in a person’s life can be regarded as a useful indicator of the problems that they are experiencing.

Fear
Fear can be described as a feeling of anxiety and agitation caused by dread, apprehension or by the presence of danger. Fear can be intrinsic (from within) or extrinsic (from an external source). Fear is evoked when an individual feels their well-being is under attack or that something essential to them is going to be taken away.

Reasons for Assaultive Behavior

Intimidation
Intimidation can have a number of meanings. Intimidation can mean making someone do something they don’t want to (bully) or being made to feel timid or afraid. Intimidation can be communicated by verbal or nonverbal actions (body language). Intimidation can make an individual afraid to try something, or cause a feeling of discouragement due to being belittled by another person’s status. Intimidation can cause someone to do something out of fear.

Manipulation
Manipulation can be defined as an action that attempts to influence others in a way so as to get what he or she wants. Manipulation can be used in a dishonest way to cause an individual to falsely believe in something. A manipulator will sometimes provide false information, use false reasoning, distort or withhold relevant information or toy with people’s emotions to achieve what they want. A manipulative individual may try to promote confusion by introducing related but irrelevant pieces of information into the conversation.

Manipulation is an attempt to get someone to do something they don’t want to do (U.S. Department of Labor Employment and Training Administration, n.d.).

When fear and frustration occur an individual may feel threatened or vulnerable and lose control. When intimidation and manipulation occur, anger may be the result. Anger may lead to an act of violence as an attempt to control the environment.

Dealing With Assaultive Behavior

The CNA should always try to remember that there is often an underlying reason for aggressive behavior in patients. Pain or discomfort, hunger, thirst, a need to go to the bathroom or fear of an unknown treatment may cause a patient to act aggressively in times of stress.

So what should a CNA do?

There are several things you can remember when dealing with potentially angry or aggressive patients:

- Try not to take their rude comments personally.
- Attend to the patient with only 1 or 2 people in the room, so that the patient does not feel overwhelmed.
- Speak in short, easy to understand, language and use a calm, non-threatening manner.
- Explain exactly what you are going to do before you do it.
- Give the patient simple commands to follow.
- If the patient starts to become hostile, attempt to redirect their focus, but never scold or reprimand them sharply.

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If necessary, excuse yourself and leave the person in a safe place. Return later to finish your care.

This is not easy to do, especially if you are having a bad day yourself or feeling stressed or overwhelmed at work. Try to talk to your nurse or supervisor if you are feeling stressed so that help can be found.

Communicate with your supervisor so that the healthcare team are made aware of the patient’s behavior.

The Assault Cycle
One method of identifying behaviors that can lead to violence is the assault cycle (Continue CPR, n.d.). Learning and understanding the phases of the assault cycle will help CNAs to identify patterns of aggressive behavior and assist them to respond appropriately.

The assault cycle identifies a pattern of behavior that can be observed in many individuals prior to an act of violence. As an individual becomes increasingly stressed about a perceived threat, the intensity of their emotions increases.

Their reaction and response to the threat is cyclical (happens again and again in the same order) and can be observed in different phases.

The five phases of the assault cycle are:
1. The triggering event phase
2. The escalation phase
3. The crisis phase
4. The recovery phase
5. The post crisis depression phase

The goal of managing assaultive behavior is prevention.

The Triggering Event Phase
This first phase of the assault cycle is initiated when an aggressor perceives that there is a threat to her personal well-being. The aggressor may experience increasing feelings of frustration that she is being deprived of something of value or that she is being ignored.

During this phase the aggressor may exhibit observable signs that she feels she is experiencing a loss of control.

The aggressor may be reacting to observable stressors such as an argument with another individual, a disturbing phone call, or a loss of privileges of some type (for example not being permitted to smoke or eat when they are hungry).

Non-observable threats could be related to delusions, hallucinations or a reaction to medications.

The Escalation and Crisis Phases
The Escalation Phase

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Once an individual reaches the escalation phase, he is preparing to fight. He might verbally challenge the potential victim at this time, especially if the victim is associated with the perceived threat. Behaviors such as yelling, banging, pacing, kicking walls and throwing objects may be observed.

The need for chemical or physical restraints may be identified at this time to prevent progression to phase three if other techniques are failing to de-escalate the behavior. It is important to alert the individual that there will be consequences for the current behavior and that changing his behavior at this time will be beneficial. Special attention to a non-threatening and calm demeanor is important so the individual does not feel even more threatened.

The Crisis Phase
The individual attacks the perceived threat during the crisis phase. Generally this phase does not last long because an individual can’t sustain the energy required to continue an attack.

The attack may be directed at the CNA, the nurse or physician, a family member or another patient, depending on whom the aggressor decides to act against.

The Recovery and Post Crisis Depression Phases
The Recovery Phase
The individual appears more relaxed during the recovery phase. The individual has not yet returned to baseline yet so another attack could be forthcoming if another perceived threat occurs.

Post Crisis Depression Phase
The individual’s behavior may show signs of depression or emotional symptoms of fatigue.

Behaviors that might be observed during this phase include crying, hiding, sleeping, lying in a fetal position, or self-blame.

Some individuals may not feel guilt or self-blame and may feel empowered or aroused by the violent event.

Be Prepared
Any interaction with an aggressive individual can be extremely stressful even for the most experienced CNA. It is always important to be prepared by asking yourself if you are able to maintain self-control.

In order to control an environment, CNAs must maintain self control and not allow a situation or an aggressor to begin to control them.

When dealing with an aggressive individual, learn to:

- Maintain an open and relaxed posture, hands in full view, ready to move quickly but not fearful
- Position yourself at a 45 degree angle slightly off to one side
- Use slow deliberate gestures
- Avoid physical contact or use only in a defensive manner
- Maintain a confident, firm and reassuring voice
- Use a logical calm and encouraging speech content, repeat if necessary
- Leave an unobstructed exit for the aggressive individual

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All CNAs should receive assaultive behavior training and be familiar with the Policy and Procedures of their particular organization.

Do Not Ignore Warning Signs
It is also very important to make sure not to ignore an aggressor’s warning signs of a perceived threat. Be alert to the presence of facial tension such as pursed lips, knotted brow, clenched teeth or fists, and tense body language. Remember to maintain control by controlling your own emotions.

Do not:
- Begin shouting or arguing
- Become hostile or punitive
- Ask for explanations of their behavior
- Make dares or threats

Body Language
Try to identify how a patient may perceive you as a threat. Hands held behind your back may suggest a hidden weapon to an aggressor, or hands folded over the chest may indicate defiance. The CNA’s posture is an important factor in escalating behavior in a patient.

In this image, what concerns might the patient have when the CNA enters the room and stands in this position?

He seems friendly, but...
Is he going to hurt me?
What does he have behind his back?
His pen and name tag can be a weapon!

Types of Assault: Simple Assault
This individual has threatened to injure someone. At the time of or prior to the assault they would likely be yelling and screaming, gesturing and exhibiting signs of anger.

This threat is considered a simple assault if:
- The person is close enough to injure
- The person shows intent to injure
- The person has the ability to injure
- The threatened injury is not serious enough to require immediate medical attention
Types of Assault: Assault and Battery
This individual is trying to injure someone. Most likely they will be yelling, screaming, gesturing, and exhibiting signs of anger. They might be purposely spitting at the intended victim.

This is assault and battery if:

- A person tries to injure another individual
- The person shows intent to injure
- The person makes physical contact
- The person has the ability to injure
- The injury being attempted is not sufficient to require immediate medical attention

Types of Assault: Aggravated Assault
Aggravated assault is assault with the use of a weapon. They might be yelling, screaming, gesturing, exhibiting signs of anger and purposely spitting at the victim.

This is considered aggravated assault if:

- The person has the ability to significantly injure immediately
- The person shows intent to seriously injure immediately
- Threats or attempts of injury would require immediate medical intervention

In the event anyone sustains an injury after an attack (victim or perpetrator); he should receive medical attention immediately!

Case Study
As you read the following scenario, try to identify the different phases of the assault cycle:

1. The triggering event phase
2. The escalation phase
3. The crisis phase
4. The recovery phase
5. The post crisis depression phase

Jules has been a CNA for about five years. He works in a medical surgical unit his local hospital. Tonight he has been asked to float to the Emergency Department. After checking in with the Charge Nurse, Jules receives his assignment which includes one of the psychiatric seclusion treatment rooms. The room is currently not occupied and the Charge Nurse assures him that if they receive any “psych” patients, a unit nurse will help him care for his patients.

Around midnight, police arrive with Sheila, a 50 year old female threatening to harm herself and her family. The patient, although combative at the scene, is now cooperative and denies that she would harm herself or anyone else. The police officers report that when they arrived at the patient’s home, Sheila was in the kitchen standing by a knife rack, touching the blades of the knives. She has superficial lacerations to six of her fingertips. Sheila’s husband told the officers that Sheila has been irritable and depressed since she lost her job about a month ago. She has been withdrawn from regular family activities and doesn't seem to care about anything anymore. She has been spending a lot of time alone in their room and has been crying even more over the past two weeks.

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Jules comments that Sheila smells like alcohol. One of the officers states that there were several empty vodka bottles found at the home. Sheila has now been brought in for an evaluation.

**Case Study**
Jules appropriately decides to ask his colleague, Lisa for help. Before approaching the patient, Lisa calls for security. Once the Security Officer arrives, Lisa introduces herself and Jules to Sheila, and they both welcome Sheila to the Emergency Department using a calm and friendly demeanor. Lisa tells Sheila that they are here to assist with her care and asks the patient if she is thinking of harming herself or others.

When Sheila responds that she does not have thoughts of harming herself or anyone, Lisa, having begun a rapport with the patient, asks Sheila to inform her or Jules as soon as possible if she has any destructive thoughts.

Lisa explains that the nurse and physician will need to examine her and it is necessary for her to dress in a patient gown. Lisa and a female security officer accompany Sheila into a private bathroom where Sheila changes into a patient gown and provides a clean catch urine sample.

*The arrival of security personnel subconsciously sends a message to Sheila indicating that her behavior is being taken seriously.*

*The presence of security also demonstrates a show of strength.*

*Although the patient may appear cooperative now, it is possible that as soon as law enforcement authorities leave, her behavior may change.*

*Although Sheila contracts with the healthcare worker that she won’t self harm or harm others, it doesn’t mean she won’t change her mind!*

*It is essential to continue to observe Sheila for any signs of fear, frustration or anger.*

**Case Study**
Jules places Sheila’s belongings in a patient belonging bag and gives them to the security officer to label and lock in the patient belonging locker. As the CNA hands the belongings to the security officer, a knife falls from the patient’s pants. Fortunately the patient no longer has access to any weapons.

Sheila is escorted to her room where she is instructed that the emergency physician will soon be in to
talk to her.

Jules wants to close and lock the door to the room so he doesn't have to worry that the patient might leave. Lisa explains that because the patient has not been placed on an involuntary hold, she is technically free to go. The door to Sheila’s room must remain open and/or unlocked.

Lisa explains that although Sheila has a legal right to leave, at this point in her care, the emergency room physician would not allow her to do so.

Lisa instructs Jules to be very observant of Sheila’s behavior and especially alert to any signs of building tension or frustration so that they can assure that Sheila’s behavior will remain under control.

It is important to test Sheila’s urine for any substances that could affect her course of treatment. This includes drugs such as narcotics, sedatives, or illegal substances. Always check with the RN to determine which urine tests need to be performed.

Case Study
Jules asks the security guards to observe Sheila while he attends to another patient. A few minutes later Jules returns to Sheila’s room and observes Sheila pacing about and talking to herself. Sheila’s jaw is clenched and she is balling her fists. She sees Jules in the doorway of her room observing her. She advances toward him, screaming that she has been waiting for hours and no one cares about her. Jules notes that Sheila has been waiting approximately 15 minutes and the physician has not evaluated her yet. Uncertain of what to do and feeling a loss of control, Jules abruptly tells Sheila to sit down and be quiet. He turns his back to her for a moment to get the physician. Sheila lunges towards Jules and grabs the stethoscope around his neck, choking him.

Fortunately Lisa and security are right outside the door. Sheila releases Jules and jumps back immediately. She crumples to the floor and begins to cry. Jules, shaken but not injured, leaves the room. Lisa speaks to Sheila in a calm, non-threatening voice. She apologizes to Sheila for the long wait and asks if she is okay. Sheila continues to cry and says she is sorry.

The emergency room physician arrives to interview Sheila. If Jules had maintained a calm and non-threatening attitude when dealing with Sheila, it is more than likely he would not have been attacked.

How should Jules have handled the situation differently?

Answer: Instead of yelling at her, Jules could have spoken in a calm, reassuring voice in an attempt to calm Sheila. Instead, his frustration with the situation triggered an assaultive response in Sheila and she attacked him.

Techniques to Avoid Assault
Whenever possible, try to de-escalate (calm down) an individual before their behavior escalates into an attack. Remember that the goal of managing assaultive behavior is to prevent the behavior before it occurs.

Behavioral techniques to avoid assault include a disciplined approach to controlling your own behavior.

Mechanical techniques to avoid assault include methods of escape to avoid injury. Although these
techniques are best demonstrated, there are methods to avoid injury that can be described and include:

- Calling for help
- Staying out of the way
- Encouraging conversation
- Escaping
- Covering up and attempting to escape
- Being patient
- Deflecting the blows and “rolling with the punches”

Choking from the Back
Whenever you turn your back on your patient, you open up an opportunity for your patient to attack. Always try to remain calm and stay in control of the environment. The following images of choking from behind depict one method that can help you to escape.

1. If you find yourself in a situation where you are being choked from behind, immediately raise your arms straight above your head.
2. By raising your arms above your head you will create a small space around the shoulders that can cause the aggressor’s grip to loosen. With your arms up, pivot slightly on your feet in the direction of the door or escape route.
3. As you pivot toward your escape route, twist your arms down forcefully toward the aggressor’s arms, causing her to lose her grip.
4. Run away quickly and call for help!

Choking from the Front
1. If the aggressor lunges for you from the front, try to stay calm and resist the urge to back up.
2. Similar to the back choke hold, immediately raise your arms above your head. This creates an element of surprise and also creates a small space that can cause the aggressor’s grip to loosen.
3. Pivot your feet in the direction of the door or escape route and as you pivot your feet, twist your arms downward toward the aggressor’s arms.
4. This movement usually loosens the aggressor’s grasp, providing you an opportunity to break free and run for help.

Arm Twist
1. In the event your patient grabs your arm and will not release you, there are many techniques for escape.
2. Resist the common reaction to pull up and away when grabbed by the arm. Instead, push your arm in a rapid downward motion toward the floor.
3. As you pull your arm down, pivot on your feet and move quickly toward your escape route.
4. Run away and call for help!

After the Attack: Staff
Staff members who become victims of assaultive behavior should always report the incident to their immediate supervisor in accordance with the facility policy. If physical or emotional injuries are Material protected by copyright.
present, the employee should be relieved of their duties and evaluated in the emergency department or employee health center as soon as possible.

Offering and arranging for psychological support is extremely important after an incident of assaultive behavior. Signs of anxiety and distress in the victim may be immediately apparent or might not manifest for days or until several weeks later.

Most facilities provide an employee assistance program or will assist the employee to find counseling services within the community. Any concerns or unusual changes in an employee’s work habits or emotional status could be a result of the attack and should be reported in confidence to the employee’s immediate supervisor. Although some employees may decline formal counseling, it is important to provide them with an opportunity to talk about their experience and submit ideas for preventative measures for the future (DHHS, 2005).

Allocating time after an incident of assaultive behavior is important to allow an opportunity to evaluate the incident, understand the behavior, and identify risk factors that might prevent the behavior from occurring in the future.

Proposals to modify any existing prevention plan that the facility has in place can also be accomplished at this time. Immediately after an attack an employee might need time away from work and might ask about filing a report with law enforcement if this has not already been done.

**Law Enforcement**
Sometimes CNAs are uncertain if they should contact law enforcement after an attack. Remember to always follow the facility policy and procedure and use common sense.

If anyone in the facility (staff, patients, visitors) becomes a victim of assaultive behavior, the staff member should immediately inform their supervisor and initiate the facility procedure.

An aggressor or perpetrator of an act of violence may go to jail. If the perpetrator of an attack is confused, suffering from dementia or has any disease process that has brought about an altered state of consciousness or confusion, the incident may or may not be considered a reportable incident to law enforcement.

Many facilities recommend that any act of violence committed by a non-patient should be reported to law enforcement and a report should be filed.

Most law enforcement agencies define and categorize violent acts into three areas: simple assault, assault and battery, and aggravated assault (Continue CPR, n.d.).

**Care of the Patient: Preventing Further Violence**
When attempts to de-escalate a patient are unsuccessful through therapeutic conversation, it may be necessary to utilize other methods to prevent them from injuring themselves or others.

Alternate forms of controlling and preventing a patient from harming himself or others may include the use of:

- Physical behavioral restraints
- Chemical restraints
- Seclusion
These methods must be utilized only after alternate methods have been deemed unsuccessful by qualified personnel.

**Reporting & Documenting Assaultive Behavior**

It is very important to report any incidence of assaultive behavior to the RN or supervisor as soon as possible, so that steps can be taken to avoid further incidents.

It is also very important to accurately document the incident as soon as possible, so that the events are clear in your memory. Documenting the incident as soon as possible after it occurs will help to maintain its accuracy.

It is also recommended that the CNA (victim) involved in an assaultive event and the supervisor or nurse manager go through details of the incident together to see if any changes to the facility's policies and procedures need to be made to better protect healthcare workers.

**The documentation should include who, what, where, when, how and why the incident occurred.**

**Failure to Report Violence**

The Joint Commission (TJC) states that by identifying causes, trends, settings and outcomes of sentinel events (such as workplace violence), critical information can be shared to prevent similar adverse events from happening (TJC, 2006a).

Many facilities withhold reporting incidents of violence or assaultive behavior for a multitude of reasons:

- Administrative pressure or fear of tarnishing a reputation.
- Stigma associated with victimization or feelings of self-blame may also influence a healthcare worker not to report an incident.
- Fear of termination or retaliation by their employer. It may seem easier for staff to ignore an incident than to have to work through it with a difficult administration.

Unfortunately, when acts of violence are not reported, the end result is a missed opportunity for improvement that could have been utilized to reduce risks.

Without accurate reporting of workplace violence, any data that has been collected will not represent all the facts and valuable information to prevent violence will be lost.

**Behavioral Restraints**

According to The Joint Commission, restraints are the direct application of physical force to a patient, with or without the patient's permission, to restrict freedom of movement. The physical force may be human, mechanical devices or a combination of the two.

Restraint, if used improperly, can cause accidental injury or death. For these reasons, the hospital needs to limit the use of restraints to clinically appropriate and adequately justified situations (TJC, 2010; Centers for Medicare & Medicaid [CMS], 2006).

After a licensed independent physician (LIP) gives an order to place a patient in behavioral restraints, it is extremely important to follow your organization's policies and procedures.
Leather restraints may be implemented; however, some facilities may use cloth restraints. Jacket restraints, also known as “posey’s” are not recommended due to the potential for self-strangulation and injury.

Never use a sheet or other device to restrain a patient; as there are many deaths over the years associated with improper restraint techniques (TJC, 2006b).

If staff had been unable to de-escalate Sheila’s behavior, the physician may have ordered that she be placed in seclusion or restraints. After a patient is placed in restraints the physician will frequently order a medication with a sedative effect.

Behavioral Restraints
Remember that a patient should be placed in restraints (also known as personal protective devices) only as an emergency safety measure for the patient and others because all other measures have failed.

Physical assessment of the patient should be performed by the RN immediately after the individual is placed in restraints, and thereafter, when appropriate to the patient’s condition, needs, and the type of seclusion or restraint employed.

Waking a patient in restraint or seclusion is not recommended as it can be dangerous for both the staff member and patient/resident/client.

Visual checks should be routinely performed if the patient/resident/client is too agitated to approach (TJC, 2006b).

Once again, remember that restraints are used to protect the patient from harming themselves or others. An order to place an adult in restraints (or seclusion) must be obtained from a licensed independent practitioner (LIP) and re-evaluated every 24 hours (TJC, 2010).

Chemical Restraints
Chemical restraints are medications that restrain an individual’s behavior. Medications that are used during an acute aggressive state are different than medications used for long term care.

Agitated patients should be offered medication as soon as possible to assist in calming them down. Medication should be individualized based on the patient’s history and medical condition.

Psychiatric evaluation should be performed as soon as possible to determine whether other problems that increase aggression such as psychosis, substance abuse, or anxiety are present.

Since certain medications may depress respirations, it is important to follow the facility policy and procedure for monitoring patients that receive sedation.

Seclusion
There may be times when a patient must be placed in restraints and seclusion. Patients such as these need to be continuously monitored by trained staff either in person or through the use of both video and audio equipment that is in close proximity to the patient (TJC, 2010).

The seclusion room should not contain any items that the patient could use to injure themselves or others. The room should be free of equipment including any wall suction apparatus or tubing of any sort.
It is extremely important that the patient being placed into seclusion is clothed in a hospital gown and their belongings removed from the room.

Entry to the room should be restricted to the primary caregivers and security. Ancillary team members such as lab technicians or respiratory therapists should never enter the room alone.

Nothing should enter the room that could be used as a weapon. At meal time, food should be served on disposable plates and in disposable cups.

Whether a patient is placed in restraints or in seclusion, CNAs should never perform any interventions without security personnel or a fellow healthcare worker standing by. The potential for injury remains high. Patients may have been able to wriggle free of restraints and be waiting for an individual to come within striking distance or they may attack healthcare personnel upon entering the seclusion room.

Always lock up patient belongings, especially their shoes, in the patient belonging cupboard. Most patients who could pose a flight risk (elope) will not do so without their shoes!

Involuntary Treatment
The National Association of Psychiatric Health Systems reports that about 88% of adults treated in its members' hospitals are admitted voluntarily.

In many states, people who are very disabled by their illnesses and who refuse hospital treatment may be involuntarily admitted to the hospital, but only by law enforcement, a trained physician or other licensed individual per state approval.

An involuntary hold is usually for a period of 72 hours (three days).

Involuntary treatment is sometimes necessary and is always subject to a review which protects the civil liberties of the individual.

7 Tips to Prevent Workplace Violence
Crisis Prevention Institute (CPI) is an organization that provides training to healthcare professionals in de-escalating violence in the workplace, and provides training in managing disruptive and assaultive behaviors.

CPI offers a short YouTube video on 7 Tips to Prevent Workplace Violence:

Conclusion
Learning to recognize the signs of assaultive behavior and preventing behavior that can escalate and lead to violence is essential for the safety of today’s CNAs. To help maintain a safe working environment, CNAs can recognize early warning signs of a pending attack, and act in a certain way to possibly prevent an attack.

Although we may never be able to explain why people act the way they act or why they become violent, we can learn to identify emotional and behavioral clues that might prevent such an act. Learning and applying communication techniques to diffuse escalating and potentially assaultive
behavior is usually much more beneficial to caregivers than allowing the aggressive behavior to occur and attempting to counter the attack by learning to perform defense maneuvers.

CNAs and others at risk of violence will benefit from receiving standardized training to assist them in recognizing aggressive and assaultive behaviors.

The primary goal of learning to manage assaultive behavior is always to preserve safety, dignity and prevent assaultive behavior before it occurs.

References


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