Your Role in Managing Assaultive Behavior

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Purpose
The purpose of this course is to provide healthcare professionals with information to manage assaultive behavior in the workplace. Following the Occupational Safety and Health Administration Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, this course will delineate the roadmap to workplace violence prevention.

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Learning Objectives
After successful completion of this course, you will be able to:
1. Identify risk factors associated with workplace violence
2. Delineate the steps for workplace violence prevention plan
3. Describe the types of workplace violence
4. Describe predicting factors that lead to aggression and violence
5. Define the assault cycle
6. Identify general safety principles
7. Discuss the use of restraints including each type of restraint

Introduction

Workplace violence is a serious problem. The National Institute for Occupational Safety and Health defines workplace violence as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty." Many people study this issue and the workplace prevention programs include verbal violence - threats, verbal abuse, hostility, harassment, and the like; which, can cause significant psychological trauma and stress, even if no physical injury takes place. Verbal assaults can also escalate to physical violence. In hospitals, nursing homes, and other healthcare settings, possible sources of violence include patients, visitors, intruders, and even coworkers. Examples include verbal threats or physical attacks by patients, a distraught family member who may be abusive or even become an active shooter, gang violence in the emergency department, a domestic dispute that spills over into the workplace, or coworker bullying (Occupational Safety and Health Association (OSHA), 2015).

Statistics

In 2013, the broad "healthcare and social assistance" sector had 7.8 cases of serious workplace violence per 10,000 full-time employees (see graph below). Other large sectors such as construction, manufacturing, and retail all had fewer than two cases per 10,000 full-time employees. This rate of serious workplace violence in healthcare is more than four times that of other industries.

Serious workplace violence – those requiring days off for the injured worker to recuperate.
- 27 out of the 100 fatalities in healthcare and social service settings that occurred in 2013 were due to assaults and violent acts
- Workplace violence in the medical occupations represented 10.2% of all workplace violence incidents
(OSHA, 2015)

Did You Know?

In 2013, 80 percent of serious violent incidents reported in healthcare settings were caused by interactions with patients. Other incidents were caused by visitors, coworkers, or other people (Bureau of Labor Statistics (BLS), 2015).

Workplace Violence Costs

When an employee requires medical treatment or misses work because of a workplace injury, workers' compensation insurance will typically have to pay the cost. For example, one hospital system had 30 nurses who required treatment for violent injuries in a year, at a total cost of $94,156; $78,924 for treatment and $15,232 for lost wages (Speroni, Litch, Dawson, Dugan, & Atherton, 2014).

Risk Factors

The risk factors for workplace violence vary among healthcare facilities; however, there are some common themes.
Patient/Setting-related
- Working with people who have a history of violence or who may be delirious or under the influence of drugs
- Transporting patients
- Working alone
- Poor environmental design that may block vision or escape routes
- Poor lighting in hallways or exterior areas

- Lack of means of emergency communication
- Presence of firearms, knives, and other weapons
- Working in neighborhoods with high crime rates

Organizational
- Lack of training and policies for staff
- Understaffing in general, and especially during meal times and visiting hours
- High worker turnover
- Inadequate security staff
- Long wait times and overcrowded waiting rooms
- Unrestricted public access
- Perception that violence is tolerated and reporting incidents will have no effect

(OSHA, 2015b)

Workplace Violence Reporting

Incidences of violence are vastly under reported! The statistics reported by OSHA and the Bureau of Labor Statistics report only violent acts that result in time away from work; thus, ***the problem is considerably larger than the official statistics suggest.***

Traditionally, 69% of physical assaults and 71% of non-physical assaults are not reported. The reasons for under reporting are many. The culture of healthcare providers is to do no harm, and this often is translated into "violence is part of the job."

Other reasons for under reporting include:
- Injuries caused by patients are unintentional
- Unwillingness to stigmatize the perpetrators due to their condition
- Lack of a reporting policy
- Fear of retaliation
- Lack of faith in reporting system
- Lack of mental health funding resulting in more mental health patients in emergency departments
  (OSHA, 2015b)

Test Your Knowledge
69% of physical assaults and 71% of non-physical assaults are not reported this may be because:
   A. Culture of Safety dominates
   B. Injuries by patients are unintentional
   C. Effective reporting system is in place
   D. Less mental health patients in the system

Rationale: Other reasons for under reporting include:
- Injuries caused by patients are unintentional
- Unwillingness to stigmatize the perpetrators due to their condition
- Lack of a reporting policy
- Fear of retaliation
- Lack of faith in reporting system
- Lack of mental health funding resulting in more mental health patients in emergency departments

Workplace Violence Prevention

The key to a safe work environment is a comprehensive injury prevention program. The Occupational Safety and Health Administration (OSHA), The American Nurses Association (ANA), and other national agencies are committed to workplace violence prevention.

Statement of ANA Position

In 2015, the ANA issued a new position statement regarding individual and shared roles and responsibilities of registered nurses and employers to create and sustain a culture of respect, free of incivility, bullying and workplace violence. Registered nurses and employers across the healthcare continuum, including academia, have an ethical, moral, and legal responsibility to create a healthy and safe work environment for registered nurses and all members of the health care team, health care consumers, families, and communities.

ANA's Code of Ethics for Nurses with Interpretive Statements states that nurses are required to "create an ethical environment and culture of civility and kindness, treating colleagues, co-workers, employees, students, and others with dignity and respect." Similarly, nurses must be afforded the same level of respect and dignity as others. Thus, the nursing profession will no longer tolerate violence of any kind from any source. All registered nurses and employers in all settings, including practice, academia, and research must collaborate to create a culture of respect, free of incivility, bullying, and workplace violence. Best practice strategies based on evidence must be implemented to prevent and mitigate incivility, bullying, and workplace violence; to promote the health, safety, and wellness of registered nurses; and to ensure optimal outcomes across the health care continuum. This position statement, although written specifically for registered nurses and employers, is also relevant to other health care professionals and stakeholders who collaborate to create and sustain a safe and healthy interprofessional work environment. Stakeholders who have a relationship with the worksite have a responsibility to address incivility, bullying, and workplace violence. (American Nurses Association (ANA, 2015)

Occupational Safety and Health Act of 1970 (OSH Act or Act)

"To assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health..."(OSHA, 2015).

Pursuant to the OSH Act:
- Employers must comply with safety and health standards and regulations issued and enforced either by OSHA or by an OSHA-approved state plan.
- The Act's General Duty Clause, Section 5(a)(1), requires employers to provide their workers with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm.
- Section 11(c)(1) of the Act provides that "No person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding or because of the exercise by such employee on behalf of himself or others of any right afforded by this Act." Reprisal or discrimination against an employee for reporting an incident or injury related to workplace violence, related to this guidance, to an employer or OSHA would constitute a violation of Section 11(c) of the Act.
- 29 CFR 1904.36 provides that Section 11(c) of the Act prohibits discrimination against an employee for reporting a work-related fatality, injury or illness.

Written 40 years ago, refined in 1989, 2004, & 2015, and still serving as the foundation for workplace violence prevention today; these generic health and safety guidelines provide employers a base to build their own health and safety plans and programs. The safety programs are not regulated by any governing body; state or federal government. In fact, most states permit private industry to develop and implement their own unique plans to manage workplace safety.
(OSHA, 2015)

Building Comprehensive Workplace Violence Prevention Program

A violence prevention program focuses on developing processes and procedures appropriate for the workplace in question. This workplace's violence prevention program should have clear goals and objectives for preventing workplace violence, be suitable for the size and complexity of operations and be adaptable to specific situations and specific facilities or units. The components are interdependent and require regular reassessment and adjustment to respond to changes occurring within an organization, such as expanding a facility or changes in managers, clients, or procedures. And, as with any occupational safety and health program, it should be evaluated and reassessed on a regular basis. Several states have passed legislation and developed requirements that address workplace violence; therefore, your organization should review any regulations in your state.

Five key factors will be discussed in the module to empower you and your organization to put into place an effective program to reduce workplace violence.   These factors are:
- Management commitment and worker participation
- Worksite analysis and hazard identification
- Hazard prevention and control
- Safety and health training
- Recordkeeping and program evaluation
(OSHA, 2015c)

Management Commitment and Worker Participation

Management Commitment: A strong commitment by management is critical to the overall success of the workplace violence prevention program. It is important for administrators, safety managers, and front-line supervisors not only to show that aggressive or violent behavior is unacceptable and will result in appropriate consequences, but also to provide an environment of trust where errors and incidents are viewed as opportunities to learn, with the overall goal of continuous improvement. Included in this process are sufficient resources and the pledge to uphold performance expectations.

Effective management leadership begins by
recognizing that workplace violence is a safety and health hazard.

This commitment should include:
- Acknowledging the value of a safe and healthful, violence-free workplace and ensuring and exhibiting equal commitment to the safety and health of workers and patients/clients
- Allocating appropriate authority and resources to all responsible parties. Resource needs often go beyond financial needs to include access to information, personnel, time, training, tools, or equipment
- Assigning responsibility and authority for the various aspects of the workplace violence prevention program to ensure that all managers and supervisors understand their obligations
- Maintaining a system of accountability for involved managers, supervisors and workers

- Supporting and implementing appropriate recommendations from safety and health committees
- Establishing a comprehensive program of medical and psychological counseling and debriefing for workers who have experienced or witnessed assaults and other violent incidents and ensuring that trauma-informed care is available
- Establishing policies that ensure the reporting, recording, and monitoring of incidents and near misses and that no reprisals are made against anyone who does so in good faith

Employee Participation: Workers can provide useful information to employers to design, implement and evaluate the program. In addition, workers with different functions and at various organizational levels bring a broad range of experience and skills to program design, implementation, and assessment. Mental health specialists can appropriately characterize disease characteristics but may need training and input from threat assessment professionals. Direct care workers, in emergency departments or mental health, may bring very different perspectives to committee work. The range of viewpoints and needs should be reflected in committee composition. This involvement should include:
- Participation in the development, implementation, evaluation, and modification of the workplace violence prevention program
- Participation in safety and health committees that receive reports of violent incidents or security problems, making facility inspections and responding to recommendations for corrective strategies
- Providing input on additions to or redesigns of facilities
- Identifying the daily activities that employees believe put them most at risk for workplace violence;
- Discussions and assessments to improve policies and procedures—including complaint and suggestion programs designed to improve safety and security
- Ensuring that there is a way to report and record incidents and near misses, and that issues are addressed appropriately
- Ensuring that there are procedures to ensure that employees are not retaliated against for voicing concerns or reporting injuries
- Employee training and continuing education programs

Worksite Analysis and Hazard Identification

A worksite analysis involves a mutual step-by-step assessment of the workplace to find existing or potential hazards that may lead to incidents of workplace violence. The assessment should be made by a team that includes senior management, supervisors and workers. Although management is responsible for controlling hazards, workers have a critical role to play in helping to identify and assess workplace hazards, because of their knowledge and familiarity with facility operations, process activities and potential threats.

Cooperation between workers and employers in identifying and assessing hazards is the foundation of a successful violence prevention program.

Once the worksite analysis is complete, it should be used to identify the types of hazard prevention and control measures needed to reduce or eliminate the possibility of a workplace violence incident occurring. In addition, it should assist in the identification or development of appropriate training.

Additionally, those conducting the worksite analysis should periodically inspect the workplace and

evaluate worker task to identify hazards, conditions, operations and situations that could lead to potential violence. The advice of independent reviewers, such as safety and health professionals, law enforcement or security specialists, and insurance safety auditors may be solicited to strengthen programs. These experts often provide a different perspective that serves to improve a program.

Hazard Prevention and Control
After the systematic worksite analysis is complete, the employer should take the appropriate steps to prevent or control the hazards that were identified. To do this, the employer should:
- Identify and evaluate control options for workplace hazard
- Select effective and feasible controls to eliminate or reduce hazards
- Implement these controls in the workplace
- Follow up to confirm that these controls are being used and maintained properly
- Evaluate the effectiveness of controls and improve, expand, or update them as needed

Implementation of engineering control strategies should include:
- Using physical barriers (such as enclosures or guards) or door locks to reduce employee exposure to the hazard
- Metal detectors
- Panic buttons
- Better or additional lighting
- More accessible exits (where appropriate).

The measures taken should be site specific and based on the hazards identified in the workplace.

Implement administrative and work practice controls when engineering controls are not feasible or not completely protective. These controls affect the way staff perform jobs or tasks. Changes in work practices and administrative procedures can help prevent violent incidents. Training for administrative and treatment staff should include therapeutic procedures that are sensitive to the cause and stimulus of violence.

A systematic incident investigation should follow immediately after the incident. This investigation should include:
- Report as required. Determine who needs to be notified, both within the organization and outside (e.g., authorities), when there is an incident. Understand what types of incidents must be reported, and what information needs to be included. If the incident involves hazardous materials additional reporting requirements may apply.
- Involve workers in the incident investigation. The employees who work most closely in the area where the event occurred may have special insight into the causes and solutions.
- Identify Root Causes: Identify the root causes of the incident. Don't stop an investigation at "worker error" or "unpredictable event." Ask "why" the patient or client acted, "why" the worker responded in a certain way, etc.
- Collect and review other information. Depending on the nature of the incident, records related to training, maintenance, inspections, audits, and past incident reports may be relevant to review.
- Investigate Near Misses. In addition to investigating all incidents resulting in a fatality, injury or illness, any near miss (a situation that could potentially have resulted in death, injury, or illness) should be promptly investigated as well. Near misses are caused by the same conditions that produce more serious outcomes, and signal that some hazards are not being adequately controlled, or that previously unidentified hazards exist.

Safety and Health Training

Education and training are key elements of a workplace violence prevention program, and help ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Such training can be part of a broader type of instruction that includes protecting patients and clients (such as training on de-escalation techniques). However, employers should ensure that worker safety is a separate component that is thoroughly addressed.

The training program should involve all workers, including contract workers, supervisors, and managers. Workers who may face safety and security hazards should receive formal instruction on any specific or potential hazards associated with the unit or job and the facility. New and reassigned workers should receive an initial orientation before being assigned their job duties. All workers should receive required training annually.

In general, training should cover the policies and procedures for a facility as well as de-escalation and self-defense techniques. Both de-escalation and self-defense training should include a hands-on component. The following is a list of possible training topics:

- The workplace violence prevention policy
- Risk factors that cause or contribute to assaults
- Policies and procedures for documenting patients' or clients' change in behavior
- The location, operation, and coverage of safety devices such as alarm systems, along with the required maintenance schedules and procedures
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults
- Ways to recognize, prevent or diffuse volatile situations or aggressive behavior, manage anger and appropriately use medications
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors
- Proper use of safe rooms—areas where staff can find shelter from a violent incident
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures
- Self-defense procedures where appropriate
- Progressive behavior control methods and when and how to apply restraints properly and safety when necessary
- Ways to protect oneself and coworkers, including use of the "buddy system"
- Policies and procedures for reporting and recordkeeping
- Policies and procedures for obtaining medical care, trauma-informed care, counseling, workers' compensation or legal assistance after a violent episode or injury

Supervisors and managers must be trained to recognize high-risk situations, so they can ensure that workers are not placed in assignments that compromise their safety.

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. At least annually, the team or coordinator responsible for the program should review its content, methods and the frequency of training

Recordkeeping and Program Evaluation

Recordkeeping and evaluation of the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made. Supervisors and managers must be trained to recognize high-risk situations, so they can ensure that workers are not placed in assignments that compromise their safety. Accurate records of injuries, illnesses, incidents, assaults, hazards, corrective actions, patient histories and training can help employers determine the severity of the problem; identify any developing trends or patterns in particular locations, jobs or departments; evaluate methods of hazard control; identify training needs and develop solutions for an effective program.

Processes involved in an evaluation include:
- Establishing a uniform violence reporting system and regular review of reports
- Reviewing reports and minutes from staff meetings on safety and security issues
- Analyzing trends and rates in illnesses, injuries or fatalities caused by violence relative to initial or "baseline" rates
- Measuring improvement based on lowering the frequency and severity of workplace violence; Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate how well they work
- Surveying workers before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness
- Tracking recommendations through to completion
- Keeping abreast of new strategies available to prevent and respond to violence in the healthcare and social service fields as they develop
- Surveying workers periodically to learn if they experience hostile situations in performing their jobs
- Complying with OSHA and state requirements for recording and reporting injuries, illnesses, and fatalities
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving worker safety

Workplace Violence Training

It is your responsibility as an employee to know and understand the potential hazards of workplace violence in your facility. Ensure that you know and understand the policies and procedures that are in place in your institution.

Did You Know?

There are "Universal Precautions for Violence?"   You should be aware that violence should be expected but can be avoided or mitigated through preparation.

The cardinal rule for preventing workplace violence: Limit physical interventions in workplace altercations unless designated emergency response teams or security personnel are available.

Workplace Violence Risk Factors Explored

Clinical Risk Factors

There are factors inherent to the job we do as healthcare providers. These factors increase the risk of workplace violence and are present every day. The biggest inherent factor is: ***intensified emotions.*** These intensified emotions evolve from:

- Pain
- Influence of drugs or alcohol
- Cognitive impairment
- Anger about clinical relationships
- Some psychiatric and medical diagnoses
    - Although some psychiatric diagnoses are associated with violent behavior, most people who are violent are not mentally ill, and most people who are mentally ill are not violent.

It is important to realize that substance abuse is a major contributor to violence.

Social and Economic Risk Factors

Social and economic risk factors create strains on health care systems and can lead to staffing shortages at a time when more people are seeking emergency services and can set the stage for violence. Factors that increase the risk of workplace violence include:

- High concentrations of poverty
- Diminished economic opportunities
- Socially disorganized neighborhoods
- High levels of family disruption
- Low community participation
- Social and cultural norms that encourage violence
- Health, educational, and social policies that help to maintain economic or social inequalities between groups in society

Did You Know?

Nurses will sometimes excuse acts of violence if they consider them to be 'unintentional' such as when they are committed by someone who is heavily medicated or cognitively impaired.

Psychologically, it may be easier to excuse unintended physical or verbal assault, but failing to report such incidents can hinder workplace violence prevention efforts and lead to future incidents

Workplace Violence Categories

Researchers have identified four categories of workplace violence. Understanding the types of violence that occur in the workplace can assist employers and employees in effectively recognizing and preventing actual and potential incidents

Worker-on-Worker

According to the Joint Commission Sentinel Event Alert: Behaviors that Undermine a Culture of Safety published in 2008 and updated in 2016, state that intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.

The Joint Commission, described the root causes for worker-on-worker violence: *Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team ... as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members. Behaviors that undermine a culture of safety continue to be a problem in health care. While the term "unprofessional behavior" is preferred instead of "disruptive behavior," the suggested actions in this Alert remain relevant."* (The Joint Commission (TJC), 2016).

Additional components concerning worker-on-work violence are:
- Perpetrator is current or former employee
- Perpetrator may attack and/or threaten current or former employees
- Responsible for 7% of workplace homicides

- May be referred to as "lateral violence"
- Includes bullying
- Frequently manifests as:
    - Verbal or emotional abuse
    - Offensive, vindictive and/or humiliating behavior

Customer/Client

This type of violence occurs when there is a relationship between the perpetrator and the employee/business and while perpetrator is being taken care of or served by the employee/business. This type of violence is perpetrated more frequently in the healthcare industry. The offenders often are students, patients, and family members.

Personal Relationship

In this type of violence, there is no relationship between perpetrator and business as in Customer/Client violence; however, the relationship is between the perpetrator and victim.
An example of this type of violence is domestic violence which occurs within the business walls.

Criminal Intent

Criminal intent violence occurs when a violent act occurs while a crime is committed and accounts for 85% of workplace homicides. There is no relationship between the perpetrator and the business/employee. The risk for this type of workplace violence increases for people who exchange cash with customers, work late hours or work alone.

Test Your Knowledge

Which category of workplace violence does: Verbal threats, uncooperative attitudes during routine activities, condescending language with colleagues; represent?

A. **Worker-on-worker**
B. Customer/Client
C. Personal Relationship
D. Criminal Intent

Rationale: Worker-on-worker: Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.
Customer/Client: This type of violence occurs when there is a relationship between the perpetrator and the employee/business and while perpetrator is being taken care of or served by the employee/business. This type of violence is perpetrated more frequently in the healthcare industry. The offenders often are students, patients, and family members.
Personal Relationship: In this type of violence, there is no relationship between perpetrator and business as in Customer/Client violence; however, the relationship is between the perpetrator and victim. An example of this type of violence is domestic violence which occurs within the business walls.
Criminal Intent: Criminal intent violence occurs when a violent act occurs while a crime is committed and accounts for 85% of workplace homicides. There is no relationship between the perpetrator and

Patient Risk Assessment

After an attack or incident of assaultive behavior, healthcare professionals sometimes describe situations in which patients suddenly and unexpectedly become aggressive, threatening, or violent without any warning signs. In retrospect, it is very possible that subtle warning signs often associated with aggression were not observed and without the proper intervention, the individual began escalating toward an outburst of anger or even worse, an act of violence.

Set aside time during the patient assessment to develop a relationship of trust as well as time to talk about risks. Also consider that the behavior could result from a pre-existing psychosis or mental health issue as well.

Areas to talk with your patient about include:
- Use of weapons in the past
- A history of dangerous or impulsive and aggressive behavior or acts
- Verbalizing intent to harm others
- Substance abuse
- Aggression trigger factors
- Recent intense stress
- Social support

Substance Abuse

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

Drug Abuse: The real danger of a drug that can make someone severely aggressive and angry is that some of them can also put a person into a physical meltdown that can result in death. Or they could become angry at the wrong person and find themselves on the receiving end of an assault.

If the angry aggression is severe enough to send the person into a breakdown, he (or she) may end up in the emergency room. Most people in this condition are unable to tell doctors what they have taken so medical staff must guess, a risky tactic when they are trying to save the person's life.

Stimulant and hallucinogenic drugs are responsible for most violent behaviors when taken for recreational use.

Alcohol: The effects of alcohol in the brain can produce aggression and violence; factors such as drinking history, physical health, amount of alcohol ingested, when the alcohol was consumed, and whether the alcohol was taken with other drugs will help determine how alcohol will affect an individual. A patient experiencing the initial symptoms of withdrawal may become increasingly agitated or violent.

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 essential. Because the goal is to stop violence before it happens, healthcare professionals must have a basic understanding of human behavior and

knowledge of specific communication techniques that will assist healthcare workers to identify and sort out risk factors that can contribute to violent or assaultive behavior.

Admission to a hospital or other healthcare facility can be an extremely stressful time for individuals, their family and friends. Establishing a supportive relationship between colleagues, patients and their significant others can help minimize misunderstandings and concerns.

Regularly completing a focused patient assessment will identify risk factors that may contribute towards violent behavior.

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.

Therapeutic Communication

Healthcare providers 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)
- Reflect facts and feelings
- Paraphrase and clarify what has been said
- Be sure to ask open ended questions

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, diaphoresis, metabolism, and a tensing of muscles. Observable reactions to stress often include social, behavioral, psychological, and physical signs and symptoms.

Social signs of stress include:

- Difficulty in accepting or giving help or support
- Blaming
- Isolation
- Unable to experience fun

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)

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

Physical signs of stress may include:

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

Real Time: Reasons for Assaultive Behavior

According to the common knowledge model of 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

Frustration is an emotion that can occur when an individual's goals are not attainable 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.

Intimidation

Intimidation can have several 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 superior wealth, fame or status. Intimidation can cause someone to do something out of fear.

Manipulation
In a behavioral context, the word manipulation can be defined as an action that attempts to influence others in a way 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.

The Assault Cycle
One recognized 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 healthcare workers to identify the patterns of escalating 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 escalates. Their reaction and response to the threat is cyclical in nature and can be observed in different phases, each one associated with behavioral, physical and psychological responses.

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 foremost goal of managing assaultive behavior is prevention.

The Triggering Event
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

The Escalation Phase
Once an individual reaches the escalation phase, he is preparing to fight. He might verbally challenge the potential victim, 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, to prevent progression to the next phase 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 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 Recovery and Post Crisis Depression

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 healthcare professional. It is always important to be prepared by asking yourself if you can maintain self-control.

To control an environment, healthcare workers 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

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

Be Prepared

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 a paranoid aggressor, or hands folded over the chest may indicate defiance. The nurse's posture is an important factor in escalating behavior in a patient.

Documenting Assaultive Behavior

Written reports of assaultive behavior should be as accurate and as complete as possible and in accordance with facility procedure. Documenting the incident as soon as possible after it occurs will help to maintain its accuracy.

It is also recommended that the healthcare worker (victim) involved in an assaultive event and the employer evaluate the management of aggressive behavior together to determine the effectiveness of any current procedures that are currently in place at the time of the incident.

The report should include who, what, where, when, how and why.

Techniques to Avoid Assault

Whenever possible, try to de-escalate an individual before they escalate into an uncontrollable crisis stage and begin 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"

Never enter a patient's room alone while they are escalating and never turn your back! Always remove any objects from your person that the patient could use to harm you or them.

While the following techniques are described here,
NEVER ATTEMPT TO USE THEM WITHOUT PROPER TRAINING BY A PROFESSIONAL

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
2. If the aggressor lunges for you from the front, try to stay calm and resist the urge to back up.
3. Like the back-choke hold, immediately raise your arms above your head. This creates an element of surprise and creates a small space that can cause the aggressors grip to loosen.
4. 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.
5. This movement usually loosens the aggressor's grasp, providing you an opportunity to break free and run for help.

Arm Twist
3. In the event your patient grabs your arm and will not release you, there are many techniques for escape.
4. 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.
5. As you pull your arm down, pivot on your feet and move quickly toward your escape route.
6. 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 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.

Allocating time after an incident of assaultive behavior is strategic in that it will allow an opportunity to evaluate the incident, provide avenues to 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 now. 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.

Did You Know?
Staff members who become victims of assaultive behavior should always report the incident to their immediate supervisor in accordance with the facility policy.

Law Enforcement
Sometimes healthcare workers 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.).

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 can injure

- The threatened injury is not serious enough to require immediate medical attention

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 can injure

- The injury being attempted is not sufficient to require immediate medical attention

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 can 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!

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.

Restraints: The Last Resort
Both TJC and the Centers for Medicare and Medicaid Services (CMS) have strict regulations guiding the use of restraints.   There are four types of restraints covered by these regulations:

- Violent/Self-harm restraints

- Non-violent/non-self-harm restraints

- Chemical restraints

- Seclusion

It is essential that you know which type of restraint you are using as the order frequency, documentation, assessment, visualization and care of the patient is very different for each type. Your facility should have policies and procedures for restraints. These policies must delineate each type and where they can be used.   It is important to note, that restraints in psychiatric units are handled differently than in-patient medical facilities.

For additional information on restraints, please see RN.com's course: Restraints: The Last Resort.

Non-Violent/non-self-harm Restraints
These restraints are used to protect medical devices and treatments from dislodgement by the patient. The physician orders them every twenty-four hours, the patient is assessed every 2 hours for criteria delineated by TJC and CMS. Restraints are to be removed as soon as possible.

Violent/Self-harm Restraints
These restraints are used to protect the patient from self-harm and the staff from harm by the patient. The physician orders are time-limited, assessment is every 15 minutes, the restraints are removed at the earliest possible time, not to exceed 24-hours.

Seclusion
Seclusion is a type of violent/self-harm restraint. The patient is placed in a room where constant visualization can occur. The patient is removed from seclusion at the earliest possible time.

Chemical Restraints
Chemical restraints are medications that are NOT part of the patient's treatment regime and used to treat aggression.   For example: a patient who receives Haldol as needed for his disease treatment is NOT being chemically restrained. However, a patient who is acting out and receives a dose of Haldol is being chemically restrained.   There are some nuances to this general statement, be sure to know your organization's policy on chemical restraints.

Did You Know?
The most dangerous situation for a patient is when he/she is placed in seclusion AND violent/self-harm restraints.   These patients must be visualized continuously AND documented on every 15 minutes.

Test Your Knowledge
A patient hospitalized for pneumonia and on CPAP is constantly taking off the CPAP, the nurse places soft wrist restraints on the patient.   This indicates that the physician has ordered:
    A. **Non-violent/non-self-harm restraints**
    B. Violent/self-harm restraints
    C. Chemical restraints
    D. Seclusion

Medications Used to Treat Aggression
Examples of medications used to treat aggression include:

Benzodiazepines
Benzodiazepines such as lorazepam (Ativan®). Lorazepam can be very effective when given for acute episodes of aggression and can be administered orally, sublingually, intramuscularly or intravenously. Staff who administer benzodiazepines should become familiar with potential side effects such as decreased level of consciousness and respiratory depression.

Antipsychotics
Antipsychotic medications such as haloperidol (Haldol) and chlorpromazine (Thorazine®) are useful during an acute episode of aggression. Haloperidol is a neuroleptic medication that can be given orally, intramuscularly or intravenously. It can have a longer lasting effect on agitation but may be associated with increased adverse effects. Other antipsychotic medications include Clozapine (Clozaril®), olanzapine (Zyprexa®), ziprsidone, (Geodon®) and risperidone (Risperidal). Patients that receive antipsychotic drugs should be observed for side effects such as altered level of consciousness, respiratory depression, seizures, dystonia and dyskinesia.

Antidepressants
Antidepressants can be used to reduce anxiety, irritability and fear. All of these emotions can progress to aggression or assaultive behavior and should be addressed. Medications such as amitryptyline (Elavil) and fluoxetine (Prozac) should be used with caution, they have been blamed for causing homicidal or suicidal behavior may be used.

Mood stabilizers
Mood stabilizers such as Valproate (Depakene) can also be used to treat aggression. Valporate, Divalproex (Depakote®) and carbamazepine (Tegretol) are usually used for long term therapy in the treatment of a number of psychiatric conditions such as dementia. Lithium carbonate (Eskalith®) is sometimes used to reduce aggression during manic episodes.

Beta-adrenergic blockers
Beta-adrenergic blockers, such as propranolol (Inderal®), have been used for long term therapy to treat aggressive behavior in a few diagnoses, including dementia, posttraumatic brain syndromes, postencephalitic psychosis, and chronic central nervous system dysfunction. Using propranolol for aggression however does have a high frequency of adverse cardiovascular effects.

Did You Know?
The above medications can be used to manage aggression, depression, panic attacks/anxiety and psychotic episodes AND can be considered Chemical Restraints if used outside the patient's treatment plan.

Planning for Prevention
Preventing violence in the workplace begins with planning. Planning should be a shared activity among various individuals from different areas. Administrators must plan, devise and put into place policies that address safety measures into the work environment. Managers must ensure that staff receive appropriate training and are informed of and adhere to the facilities policies and procedures.

Although violence in the workplace continues to occur with sometimes horrifying outcomes, there are no sanctioned federal regulations in place. And, despite new developments in understanding human brain development and the human genome, there has been minimal incorporation of this information applied toward the prevention of violence. Information about understanding the standards of behavior in cultural and ethnic groups have not been addressed either. Without a standardized plan or prevention strategy, the risk of workplace violence will remain a serious hazard to healthcare employees. The field of violence prevention needs reliable, valid measurement tools to determine the effectiveness of previous years of violence intervention techniques.

Even though a facility may have developed individualized plans for managing assaultive behavior, individualized plans are inherently flawed because they lack national standardization. Non-regulated training plans have:

- An increased potential for miscommunication due to subjective interpretation of plans
- A lack of standardized language
- Inconsistencies related to the facility or unit specific needs
- Increased potential for errors

Case Study:
Jules has been a registered nurse for about five years. He usually works in the medical surgical and telemetry float pool; however, tonight, he has been asked to float to the Emergency Department.

Around midnight, police arrive with Sheila, a 50-year-old female threatening to harm herself and her family. During the assessment, Jules finds: a cooperative, though disheveled woman, with an odor of alcohol and superficial lacerations to her hands. Her history, supplied by both the police officers and her husband describe combativeness at the scene, threats to harm herself, depression with crying since losing her job, with an escalation of the symptoms in the last two weeks.

Jules, having just completed the workplace violence training knows he should:
  A. Respond to Sheila in a calm and reassuring manner
  B. Call Security immediately

Jules helps Sheila get comfortable in a room and with the aid of a female nurse assists Sheila into a hospital gown and getting labs drawn. Jules checks with Sheila to see if she needs anything, she says no, and he goes to provide care to another patient.   Sheila's husband is in the room and the police officers remain outside the room.

Upon his return, he sees Sheila pacing about and talking to herself. Sheila's jaw is clenched and she is balling her fists. Her husband states that she is upset that the doctor has not been in to see her and she wants to leave. Jules checks his watch and notes that only 15 minutes has passed.   He would:
   A. Instructs the husband to tell Sheila to be patient, after all this is an emergency department and the doctors are busy
   B. Tells Sheila if she does not calm down, he will remove her husband and lock the door
   C. Speaks to Sheila in a calm, non-threatening voice, apologizes to Sheila for the long wait and asks if she is okay.
   D. Tells Sheila she is free to leave at any time

What was his best course of action? Exactly! "C".   Maintaining his calming manner will help deescalate the situation.

However, Sheila is not appeased, she begins to hit her head against the wall and kick the bed. Her turn to more aggressive behavior should be treated by:

   A. Giving her a sedative dose to calm her down
   B. Placing her in restraints and seclusion
   C. Placing her in a room designed to keep her from hurting herself and placing a sitter outside her room
   D. Calling the police officers into the room to control her

In this circumstance, Jules chose "C".   Why?   Even though placing her in a room designed to keep her from hurting herself is a type of restraint, she will be under constant observation. This is the least invasive type of restraint and may be effective enough to calm Sheila.

The laboratory results are back and the physician is here to examine Sheila. He notes that Sheila has calmed and is sorry for her behavior.   She admits that she has been depressed and drinking, since losing her job.   She feels worthless and thinks her husband is unhappy with her.   She might as well kill herself and free him.

What should the physician do?

Did you consider a psychiatric consult?   Would you let her go home? Would you keep her safe until the alcohol dissipates? Would have the physician prescribe a common antidepressant?

The physician diagnosis depression and her labs show she is legally impaired by her alcohol consumption.   He is not an expert in depression, but knows the effects of the alcohol will wear off.

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 workforce. To help maintain a safe working environment, healthcare workers rely on effective policies and procedures, their ability to identify risk factors, the signs of a pending attack, and how to control an environment to prevent the 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.

Healthcare workers and others at risk of violence will greatly benefit from receiving standardized training that will assist them to recognize 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.

Resources

A workplace violence toolkit. Emergency Nurses Association (ENA).
http://www.ena.org/IENR/ViolenceToolKit/Documents/toolkitpg1.htm

Preventing Workplace Violence: A Roadmap for Healthcare ... - OSHA
https://www.osha.gov/Publications/OSHA3827.pdf

Preventing Violence in the Healthcare Setting. The Joint Commission Sentinel Event Alert.
http://www.jointcommission.org/assets/1/18/sea_45.pdf

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