Strategies for Managing Aggressive, Violent and Potienially Violent Patients and Safety Precautions for the Nurse Practitioner

ANUMOL TOMY

*Lecturer, Dashmeesh College of Nursing, SGT University, Gurgaon, Haryana, India.

Abstract

Aggression and violent behaviour can be attributed primarily to lower levels of serotonin. Apart from it there are other causes like family rearing practices, psychiatric illness or being under the influence of psychoactive substances. The risk factors in the potential for violence identified are past history of violence, client diagnosis and current behaviours. Working closely with aggressive and violent patients places the nurse at risk for being victimised. Rapid and efficient management of aggressive, violent and potentially violent patients is a critical skill. Effective violence management programs (that can be given as in-service education or induction program for nurses new to psychiatric units) can reduce the incidence of violence. Management of aggressive behaviour can be implemented to empower nurse practitioners to take precautions whenever necessary in a quick and efficient manner when dealing with aggressive, violent and potentially violent patients. Not all violence can be prevented, but with instruction, precaution, and training, violence can be successfully and effectively managed.

Keywords: Aggression; Violence; Debriefing; seclusion.

Corresponding author: Anumol Tomy, 15/203, N.R. Complex, Srinivaspuri, New Delhi-110065, India.

E-mail: anu000712@yahoo.com

Introduction

All of us get angry at one or the other point of time but the intensity, frequency and duration of anger threshold varies from one individual to other. Being angry often affects one's physical as well as psychological health eventually leading to many life threatening complications. Alexander[1] identifies a cluster of characteristics, as given below, that describes anger:

- Intense distress
- Frowning
- Gritting of teeth
- Pacing
- Eyebrow displacement(raised, knitted, lowered)
- Clenched fists
- Increased energy
- Withdrawal
- Flushed face
- Emotional over control
- Change in tone of voice (either lowered, with words spoken between clenched teeth, or yelling and shouting)

Alexander[1] states that aggression can arise from such feelings states as anger, anxiety, tension, guilt, frustration and hostility. It has been evident that mental illness and aggression

are closely associated. The Oxford Dictionary[2] defines violence as 'behaviour involving physical force intended to hurt damage or kill someone or something'. Children as well as adults are now bombarded with scenes of interpersonal violence highlighted by the media.

It has now become a common scenario in the life of nurses to have either experienced or witnessed being threatened, abused, attacked, harassed or confronted with a weapon by an aggressive patient. None of us can predict the future violence; aggression is usually a symptom of an underlying condition. The best type of management of any potentially violent patient lies in its prevention. Lewis and Dehn[3] found that assaults by clients in the community were caused partly by stressful living situations, increased access to alcohol and drugs, availability of lethal weapons, and noncompliance with medications. Implementation of effective violence reduction strategies can empower nurse practitioners to adopt precautionary measures when required to deal with an immediate crisis situation.

Shepherd and Lavender[4] found that aggressive behaviour was less common on psychiatric units with strong psychiatric leadership, clear staff roles, and planned and adequate events such as staff–client interaction, group interaction, and activities. Conversely, when predictability of meetings or groups and staff–client interactions were lacking, clients often felt frustrated and bored and aggression was more common and intense.

The capability to deal with aggressive patients and to perform diligently and vigorously in such emergencies demands critical thinking skills on the part of the practitioner. Violent management strategies must be adopted both in inpatient and outpatient departments due to reasons like minimal staffing, existing staff may not be equipped with required knowledge or skill, minimal inpatient stays. The pervasiveness of violent patient must be documented immediately.

It is obvious that if a violent and aggressive patient is prescribed involuntary hospitalization, given medication, put in a crowded non therapeutic setting or put on seclusion or restrain, the threshold of his aggressiveness would increase and managing such patient would in turn be difficult. Understanding the psyche behind the violent patient is important as well as taking precautionary measures for self, the entire fraternity of nurse practitioners and all the caregivers is an immediate concern.

Safeguarding Measures to Be Taken By the Nurse Practitioners

The nurse mangers should collaborate with other mental health professionals and conduct staff training programs focussing on global safety issues. Safety precautions should be taken when approaching the patient, right from the assessment phase. The nurse should introspect her own fears and anxieties in the pre interaction phase as it may exacerbate patient's agitation and may interfere with the assessment process. The nurse should introduce herself in the first meeting itself and her role as a helping professional in the process of recovery, however emotionally instable, intoxicated or disoriented patient may not be able to retain some information.[5]

The nurse should institute several measures to create several respectful, supportive contexts when interviewing the patients. Nijman and Rector[6] discovered that lack of psychological space—having no privacy, being unable to get sufficient rest—may be more important in triggering aggression than a lack of physical space. In addition to assessing the milieu, the nurse should monitor the patient carefully.

The three elements have been identified as key risk factors in the potential for violence: past history of violence, client diagnosis and current behaviours.[7] Also the situational and interactional factors associated with violence must be assessed. There should be same consistent staff approaching the patient every time as it is helpful in building rapport with the patient. It should be kept in mind that when interviewing the patient in a room, always sit near the door. Empathy can be conveyed

through active listening. The patient should be given his own personal space and avoid touching the patient without prior intimidation as it may be perceived as threatening to him.

Crucial details that a clinician may investigate to learn about a patient's history of violence include:

(a) chronology of violent episodes from onset to present;

(b) target(s) of violent behaviour;

(c) severity of injury or intended injury from violence;

(d) associated symptoms surrounding a violent episode;

(e) ownership and use of weapons and weaponry skills;

(f) criminal and impulsive behaviours such as destruction of property, reckless driving, suicide attempts, and self-mutilation remnants that may include cigarette burns, scars, and self-made tattoos.

In addition to obtaining detailed violence, family, and medical histories, mental status examination should be carried out. A thorough mental status examination allows to investigate delusions and hallucinations; delirium associated with neurological disease; signs of substance intoxication or withdrawal such as slurred speech, uncoordinated movements, dilated or constricted pupils, tremors, the smell of alcohol, and organic disruption of higher cognitive capacities. Finally, clinicians should conduct routine laboratory tests in order to help provide an accurate diagnosis and subsequent management and treatment for the patient.[8,9,10]

The specific non verbal communication used by the nurse can also greatly affect the outcome of the intervention. A calm and relaxed posture that does not tower over the patient is much less intimidating than posture in which hands are placed on the hips and nurse looms over the patient. Crossing the arms across the chest is another posture that communicates emotional distance and reluctance to help. The nurse's hands should be kept out of pockets and open posture should be maintained. Also nurse must maintain an eye contact with the patient when interacting with the patient. Simple strategies like sitting with the seated patient, standing with the standing patient and walking alongside with the patient ,using simple short sentences and avoiding laughing or smiling inappropriately depicts willingness and enthusiasm to learn more about the patient's agitated behaviour conveys mutual understanding. Encourage the patient to communicate his concerns without interruptions and engage the patient participation in treatment decisions by providing information as much as possible. Communicating the expected behaviour encourages the patient to maintain control of his violent behaviour.

Staff debriefing[7] should be done that means the violent episode should be discussed with the staff and others. It includes who witnessed the incident in terms of what happened, what could have been done that would have prevented the incidence, the necessity of seclusion and restraining and how the client and staff felt in terms of seclusion and restraining. Some cathartic activities like physical activities can be useful in releasing aggression. Limit setting is a non-punitive, non manipulative act in which the patient is foretold about acceptable behaviour and the consequences of behaving unacceptably. Nurses must understand that whenever limit setting is implemented, the maladaptive behaviour will not immediately decrease; in fact it may briefly increase.

Lepage *et al*[11] found an association between increased numbers of young adults (18 to 20 years of age) on inpatient psychiatric units and higher rates of violence. It is important to consider the environment for all clients when trying to reduce or eliminate aggressive behaviour. Planned activities or groups such as card games, watching and discussing a movie, or informal discussions give clients the opportunity to talk about events or issues when they are calm. Activities also engage clients in the therapeutic process and minimize boredom. Scheduling one-to-one interactions with clients indicates the nurse's

genuine interest in the client and a willingness to listen to the client's concerns, thoughts, and feelings. If clients have a conflict or dispute with one another, the nurse can offer the opportunity for problem solving or conflict resolution. Expressing angry feelings appropriately, using assertive communication statements, and negotiating a solution are important skills clients can practice. If a client is psychotic, hyperactive, or intoxicated, the nurse must consider the safety and security of other clients, who may need protection from the intrusive or threatening demeanour of that client. Talking with other clients about their feelings is helpful, and close supervision of the client who is potentially aggressive is essential.[12]

It is the responsibility of the nurse to check at the time of admission that patient has no weapons, glass utensils, razors, blades, knives, rope or any long cloth that could be used as a medium for harming self or others when experiencing anger episodes . In order to detect the presence of weapons, metal detectors searches must be made available. Also panic buttons should be installed and locations should be marked.[5] Provision should be made so that the patient's bed is at place near to the nurse's station through which continuous vigilance can be done. Nurses should not approach the patient alone, or if approaching the patient ensures that other nurses are aware where one is and help can be provided when needed. It is constructive to avoid initial derogative remarks made by the patient .Avoid touching the patient when he or she becomes angry.

Talking down technique is also employed for bringing the agitated patient into a calmer state with the intention of preventing the occurrence of violent behaviour. It comprises a number of naturalistic skills which nurses have used. The nurse can also refer the clients to anger management groups (once the anger falls down) where they are taught problem solving and conflict resolution techniques.

Behavioural contracts (nursing care is planned to eliminate rewards the patient receives also allowing the patient to assume as much as control as possible over violent behaviour), time outs(socially inappropriate behaviour can be decreased by short term removal of the patient from the situation) can be used also to gain control over anger and violence and token economy can be used to bring the desired behaviour.

The nurse should not administer chemical restraint to patients intoxicated with alcohol or other depressant agents, for the combination of neuroleptic medication and such agents may endanger a patient's level of consciousness.[5] When patient becomes unmanageable that is through behavioural therapies and medications, restraining and seclusion becomes the last resort. It has to be prescribed by the physician in written order. Care should be given during restraining also. The nurse should see that the patient's need for nutrition and elimination are met. Also the extremity that is restrained must be inspected to check for proper circulation. As per the instructions given by JCAHO[13] (Joint Commission on Accreditation of Healthcare Organizations) reissuing a new restrain must be done every 4 hours for adults and every 2 hours for children.

Conclusion

Nurses in every practice setting face the challenge of caring for perpetrators of violence. Lack of adequate education and training on the part of the nurses in terms of aggression and violence management can bring detrimental outcomes to nurse, patient himself, other patients or caregivers like physical injury or as fatal as death even. Developing an understanding of the causes and effects of violent behaviours enable to intervene in a therapeutic manner and provide comprehensive care. In the era of managed care and reduced staff ratio, violent incidences tend to become more recurrent. The three elements have been identified as key risk factors in the potential for violence: past history of violence, client diagnosis and current behaviours. Violence management strategies should be implemented at both institutional and

professional level. The best type of management of violence lies in its prevention. Though not all violence can be prevented, but with instruction, precaution, and training, violence can be successfully and effectively managed. In all acute care settings written policies should be made available regarding violent and potentially violent patients.

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