Aggression and violence against hospital staff

(Regulations-what to do-common cases-recommendation etc.)

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Introduction/Theoretical background

Aggression is defined as a behavior in which is apparent the intention to cause painful stimuli to an individual (man or animal) or destructive intention towards objects. People aggression manifests mainly in three types: Verbal aggression, physical aggression towards others and physical aggression towards objects. Violence usually has the meaning of physical aggression towards people, thus being a subunit of aggression. **[1]**

A person's (patient or visitor) aggressive behavior depends on factors from his/her background (social-economic-childhood), immediate environmental factors and possible co-existing medical conditions (organic or psychiatric). **[1]**

Apart from patients or visitors, a situation might make the clinician aggressive as well or on the other side afraid. In both cases is better to stop interviewing and call the security (if no other organized plan exists) or ask for the presence of another person**. [1]**

As is obvious, aggressive behaviors and violence can obstruct the tasks of hospital staff, and/or put them in danger. Workplace violence is a risk factor for health workers. Among their duties is to assess, prevent when possible, or cope with it in everyday professional practice. **[2]**

The impact of violence on staff members causes elevated stress levels and other negative feelings, such as anger, guilt, loss of motivation and avoidance behavior, the latter meaning that the staff cooperation gets impaired. In hospital level, apart from the staff feelings, we have increased ask for sickness leave, which increases the functional cost of the hospital. The financial cost is also raised because of litigation against perpetrators and by the cost of maintaining the security equipment. **[2]**

Clinicians should be aware to notice some early warning signs preceding any aggressive trends of patients or visitors. These signs vary: Nervous gestures, movements or walking, very

close approach, raised voice tone, hitting walls, items or themselves, excessive sarcasm. Sudden pause of activity may indicate that the person is planning some violent action. **[2]**

In regard with the causes of aggressive or violent behaviors, background factors include social status: Work and other activities, residency (village-town-city), education. This field includes as well physical or psychological abuse (battery) in childhood. Screen violence is increased lately, contributing to the easier adoption of these behaviors. **[1]**

Depending on health care setting, immediate environmental factors include prolonged waiting time, violated priority, inappropriate staff behavior, not sufficient staffing, inappropriate environment (e.g. not enough seats, no air-conditioning, no water, overcrowded). **[2]**

Medical factors have to do individually with each patient: Alcohol or other substances abuse or withdrawal, psychiatric disorders and organic conditions are most important. The latter includes hypoxia, hypoglycemia, cerebral insult, brain tumors, sepsis, metabolic disturbances, organ failure, and prescribed drugs used for some conditions (e.g. steroids, amphetamines**). [3]**

Physical environment should be proper, in order to prevent, de-escalate or manage aggressive behavior or violence. Improving it (enough space-seats-destructed material replacement-appropriate temperature- water) could be a first step. A reception desk should be accessible to all patients and visitors so they can be informed easily and all time about the timetable or about the expected waiting time. For security reasons, sufficient lighting and curved mirrors would be a good idea so there are no dark or hidden spots. Security cameras would help in early detection of any aggressive trends. Panic buttons, with liaison to local police department could help to confront any serious situation**. [2][4]**

In order to de-escalate aggressive behavior, talking with patients or visitors is the preferable method and always the first to use. Preferable if possible is to move the patient to a calm environment with less or no other patients, thus avoiding tension. Isolated with a patient is

not the best practice; presence of one more staff member is desirable. An open door allows either you or your patient not feel trapped. Keeping a distance from the agitated person and avoiding touching him/her is a good way for the patient not to feel threatened. Keeping dialogue one to one the agitated individual does not feel attacked. Personnel must speak in a calm manner, directly and honestly about the situation and what it can happen. Personnel set the limits, but at the same time hearing carefully one could recognize the point of tension. Showing understanding and compassion to the patient, leads him/her to understand you are not against him. Just giving orders to an agitated person is not a desirable practice. Staying alert throughout the interviewing, one ensures safety of himself, the people around and also the specific agitated patient**. [2]**

Chemical restriction, could be necessary or useful, if talking alone has not the desired effect (in many cases can be combined with physical restriction for patient's safety). This restriction can be applied voluntarily or involuntarily. An attempt should always be done to make the application of chemical restriction voluntarily by saying something like: "You will feel better more quickly if I give you this now". **[3]** Many patients accept it very well. Different drugs are used according to the magnitude of the problem/tension. Close monitoring is necessary**. [3]** When previous attempts of verbal de-escalation and chemical restriction have failed, protective actions must be taken for the safety of the patient itself and the rest of the people around him/her.

Physical restriction should be done if absolutely necessary and only to facilitate diagnosis and treatment. This type of restriction should be done by trained staff, so injuries are prevented. **[5]** Monitoring must exist and be continuous or in short time intervals, once the patient is stabilized. The restrain team should enter together and begin the process. Participation of treating physician should be eliminated during this process if possible. Strict documentation should be kept, including the time and type of restriction, and the monitoring. In monitoring (that should be

done every 15min or less) have to be checked: Vital signs, nutrition, hygiene, injuries, and psychological status, so when restriction is not necessary, we can release the patient from it**. [5]**

The above approaches, that all healthcare professionals must be familiar with, can be improved in their applications in many ways. First of all reporting of violent or aggressive behaviors should be done as much as possible when it happens. Unfortunately, there is a big percentage of underreporting. There are three reasons for this. First, the perception of professionals that patient's aggression is a part of the job, second that they feel there is no benefit from reporting, and third that they do not have always the time needed to fill in report forms. **[6]**

Efforts are being done for health care professionals to participate in studies by filling in questionnaires (so we can know better the situation in clinics and set better standards for all hospital staff). These questionnaires are good tools to help us understand the situation in each hospital and set a plan. The existing tools in use are SOVES-G-R, POAS and POIS. SOVES-G-R is one of just a few internationally validated tools. SOVES-G-R specifically is a questionnaire regarding violent episodes collecting data for each episode (which people took part in it, under which circumstances, when, and the consequences of it). **[7]**

It was observed that the lowest feedback response is coming from medical doctors and the highest from nurses and midwives. This is explained by the fact that most studies give higher violence incidence to nursing staff than medical doctors. Members of medical doctors with a higher aggression incidence are females and international students**. [8]**

A result of such clinical tools is the rapid response team approach otherwise called "Code S". This team provides the best possible care for an escalating individual. "Code S" serves two necessities: feeling of the staff being overpowered in dealing with escalating individuals every day, and the traditional "show of force". The second component is converted nowadays to "show of support", because the clinician should be controlling the situation. It is better for the patients

and the staff to know that help is standing nearby. Sometimes the security staff is preferable to stand out of the sight of some patients, so they don't escalate further. The desired outcome is to reduce patients restraint by any means**. [9]**

Another measure to help reduce aggression and violence in the hospitals is the "team triage", a team which regulates the priority of patients, according to the urgency of the condition. This team can reduce waiting time in emergencies. All patients can be screened and discharged within 15-20 minutes, or less. By assessing the patient very fast the clinician can send him/her for the necessary diagnostic tests while examines the next one, thus saving time and space in the emergency department. **[10]**

Discussion

It is obvious that we cannot fully eliminate the aggressive behaviors against hospital staff regardless of the hospital security measures, **[11]** because of the emotional distress hospital environment impacts to patients and visitors. Further causes are differences in cultural or ethical background of patients, visitors and staff, and difficulties from the immediate hospital environment. **[1]**

Any member of the hospital staff can confront such behavior, but nurses are post prone, followed by female doctors and international students. **[8]**

The best practice is preventing aggression and violence by any possible ways. Measures that improve hospital facilities, reducing waiting time, discreet security presence and "team triage" could be some of them. **[2] [10]**

Hospital security system must be re-examined regularly in regard with its ethical, transparent and effective work. The staff must be kept updated with special ongoing education. **[11]**

Recording and reporting any case of such behaviors is a very good way to improve experience and lead to best measures against aggression and violence, but unfortunately there is underreporting. Reasons for this are that staff regards it as a part of the job, they feel there in no benefit from reporting, and they have not sufficient time to complete report forms. Moreover, some administrators try to avoid this information due to much more concern and work this means for them. **[6] [12]**

De-escalation, first by talking to aggressive persons should be the first attempt to control the situation**.** If this fails, one could proceed to physical or chemical restriction in order to achieve control of a violent patient or visitor, while in the meantime attempt to reveal or exclude any medical conditions should be done. **[3] [5]**

"Code S" team should be the last involved and preferably in a discreet manner. Treating doctor must not be present when security or "Code S" team gets action. **[9]**

Every effort to prevent aggression and violence should be done by everyone, because these behaviors may contribute at burn out of the staff. It reflects the work output of the hospital in total but also the staff as individuals (low work moral, low trust, elevated stress). Depending on the type of the hospital, every care-giver is at risk, but nurses are the most. **[13]**

Working in such an organized manner as described above demands the regular training of staff. This can be done in individual hospitals or in a collective setting, the "joint commission". The joint commission is a non-profit organization, that aims to continuously improve safety and quality of care provided by public hospitals through provision of health care accreditation and related services that support performance improvement in health care organization. There are a lot of programs created for staff training and especially for emergency department overcrowding and hospital emergency preparedness. **[14]**

Strategies to early detect aggressive or violent patients help to prevent and manage such behaviors. On this direction the "Aggressive Behavior Risk Assessment Tool", is a tool that can provide information about possible violent patients in hospital wards in a prospective manner. **[15]**

Conclusion

Aggression and violence from patients and visitors in hospitals is a worldwide phenomenon that cannot be eliminated at all. Measures to prevent, to de-escalate or to manage this when it happens, must be one of the priorities for each hospital or any health care institution. It is important because it ensures safety for patients, visitors and staff, and improves health care quality. More detailed reporting, study and communication between involved health care workers, as well as staff training and awareness for early detection of aggressive or violent patients, could be the best means for further improvement in this universal hospital problem.

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