

# Managing workplace aggression in a healthcare setting

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# Workplace aggression

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- ❑ Violence or the threat of violence against workers.
- ❑ Range from threats and verbal abuse to physical assaults.



# How common is it?

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- **“Categorization of Inpatient Violence  
in IMH’s adult psychiatric wards between Oct 2009 to  
March 2010”**



# How common is it?

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- Aim: To study the assaults committed by adult inpatients in the adult wards at the Institute of Mental Health over a 6-month period (1 October 2009 to 31 March 2010)
- eHORs (electronic incident reporting system) cross-referenced with CPSS (electronic inpatient discharge summary)



# How common is it?

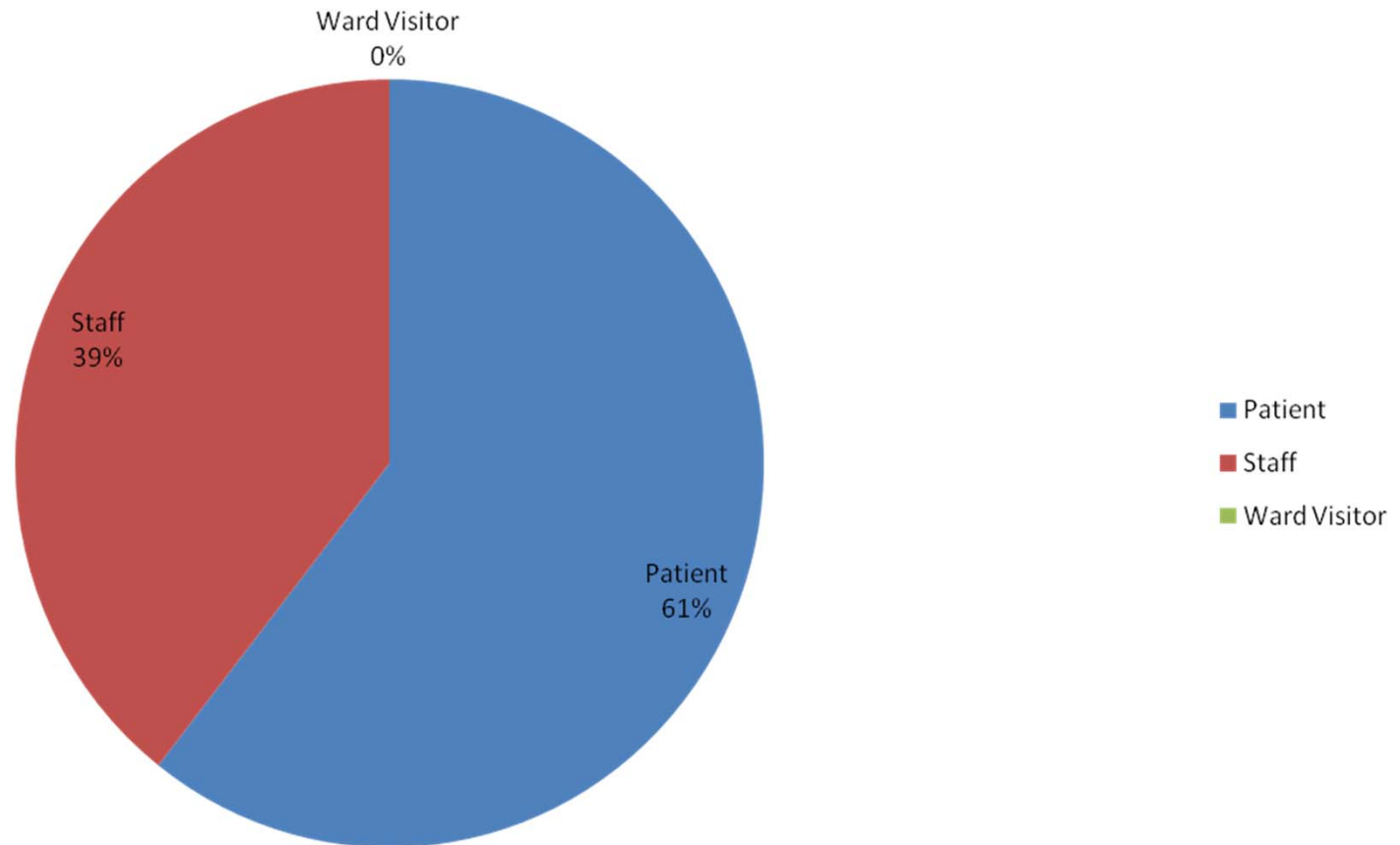
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- 236 assaults
- Classified into:
  - Psychotic
  - Impulsive/ Reactive
  - Organized/ Instrumental



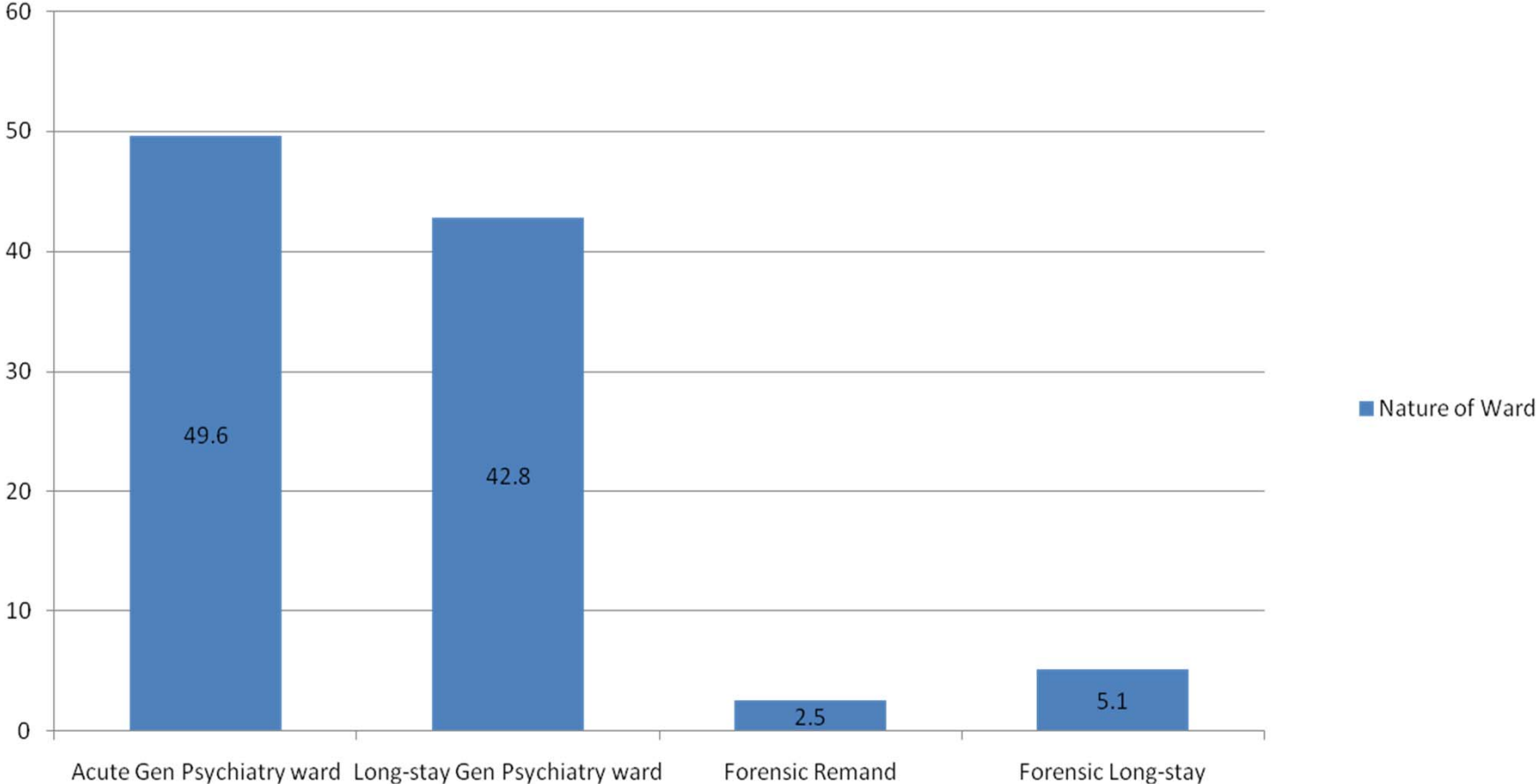
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## Target Victims





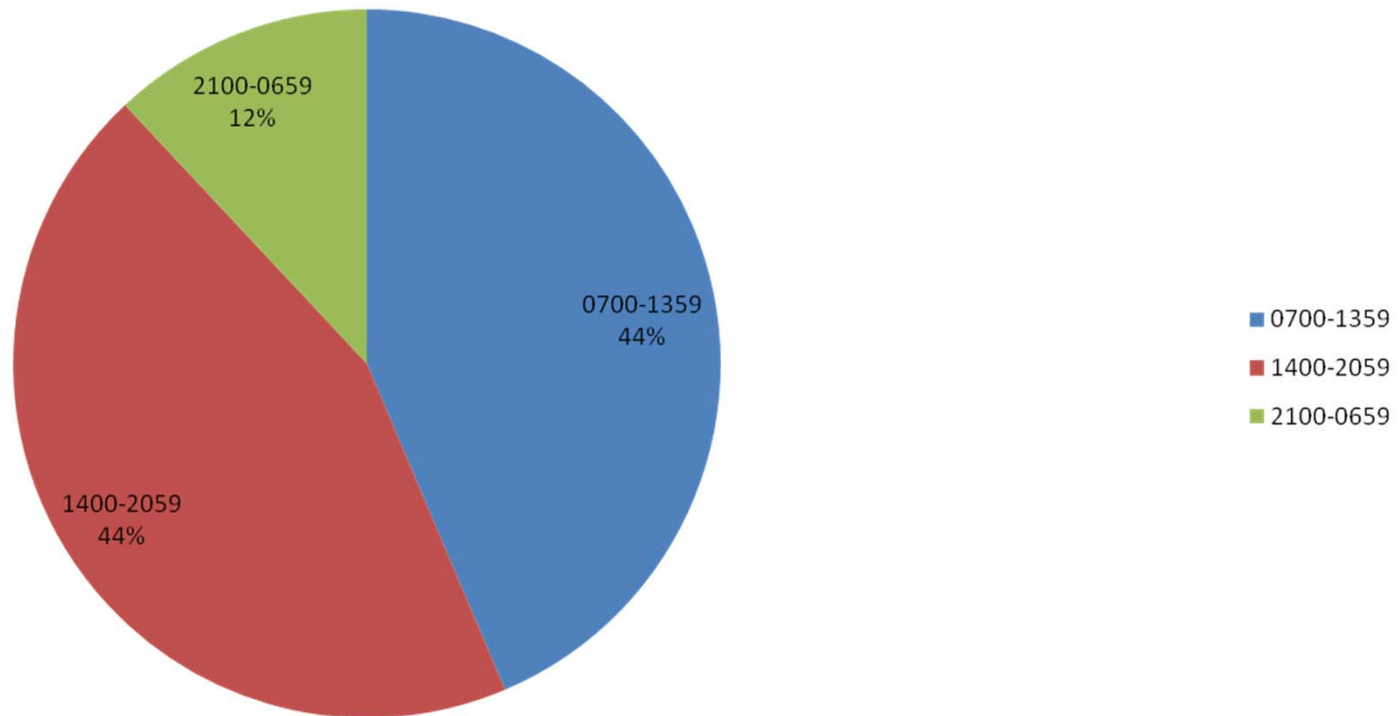
### Nature of Ward





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### Time of Assault



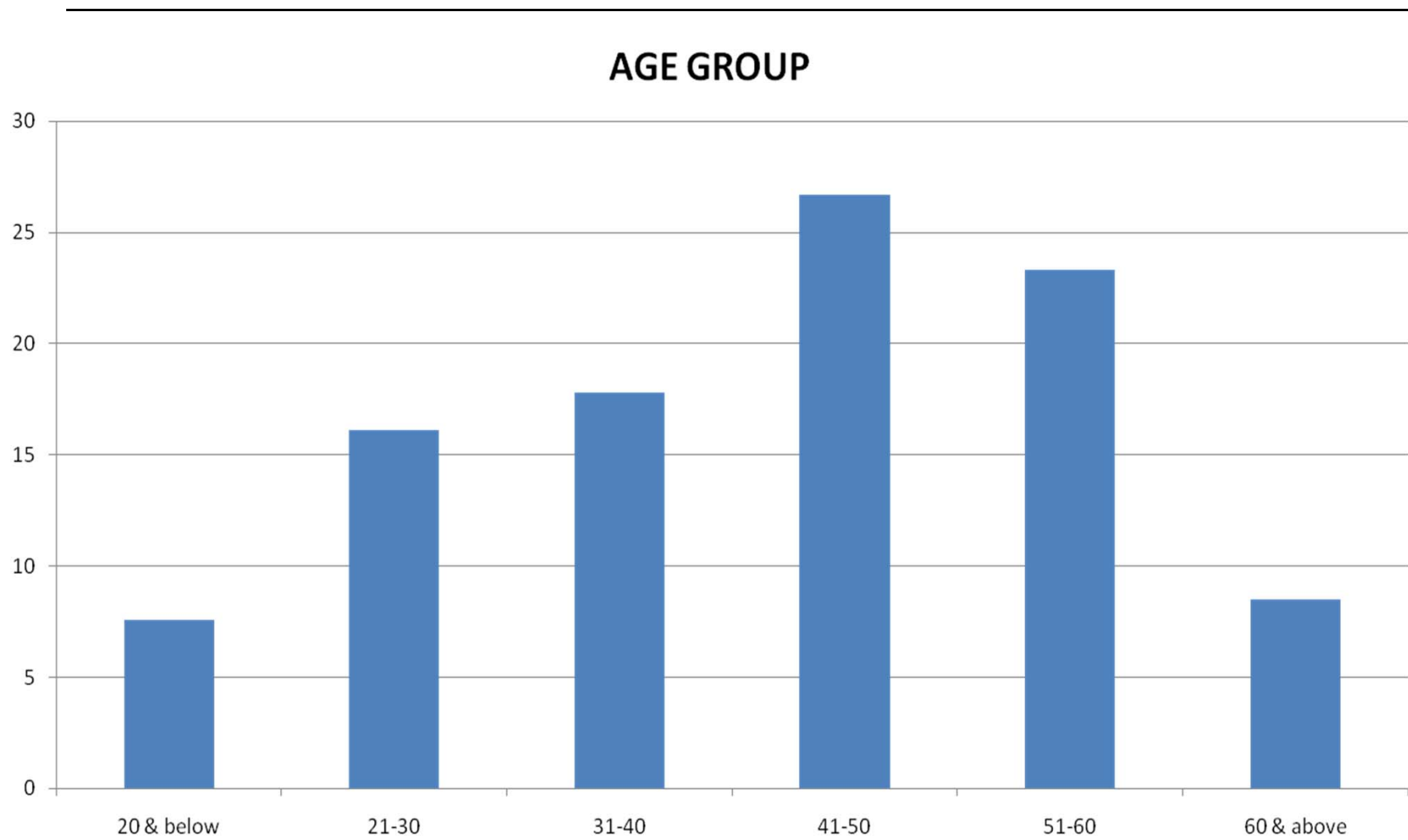
# Can we predict who will be violent?

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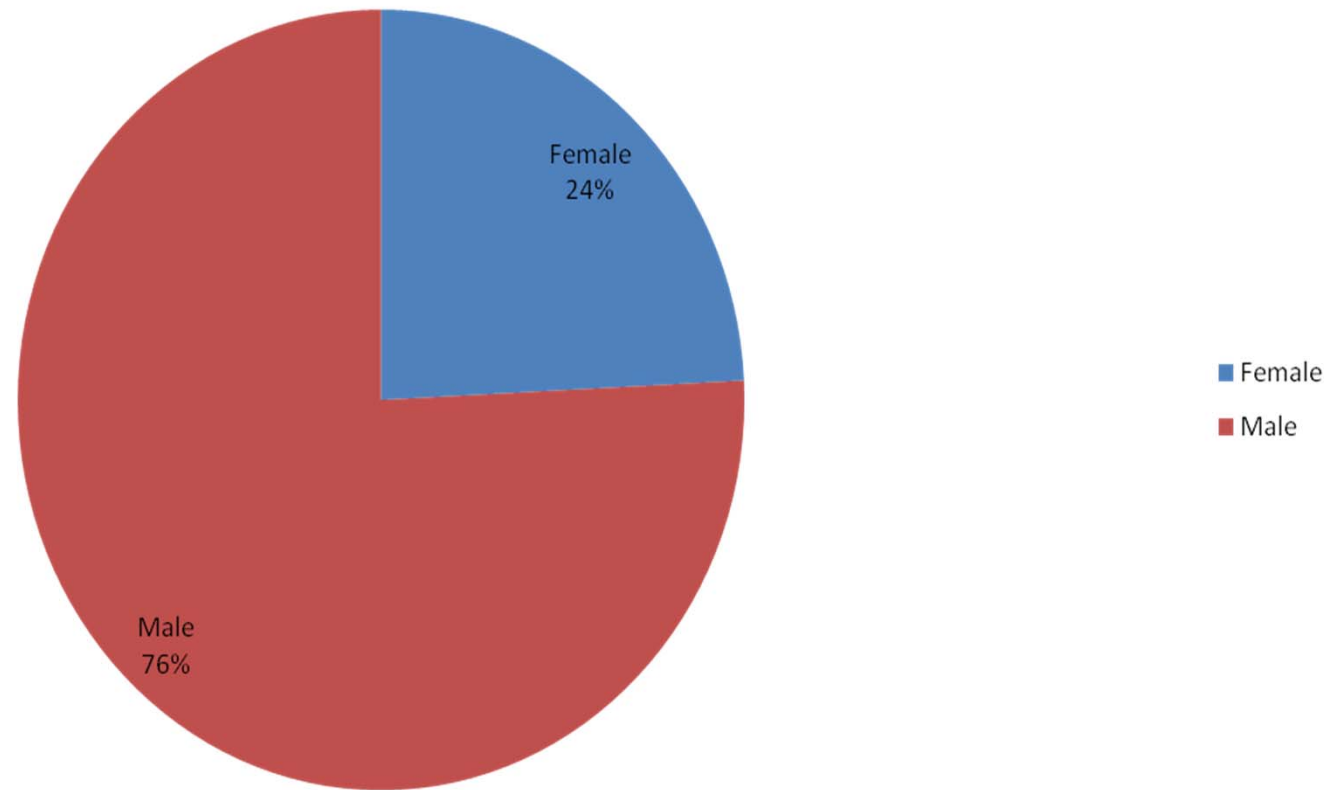
# Results:





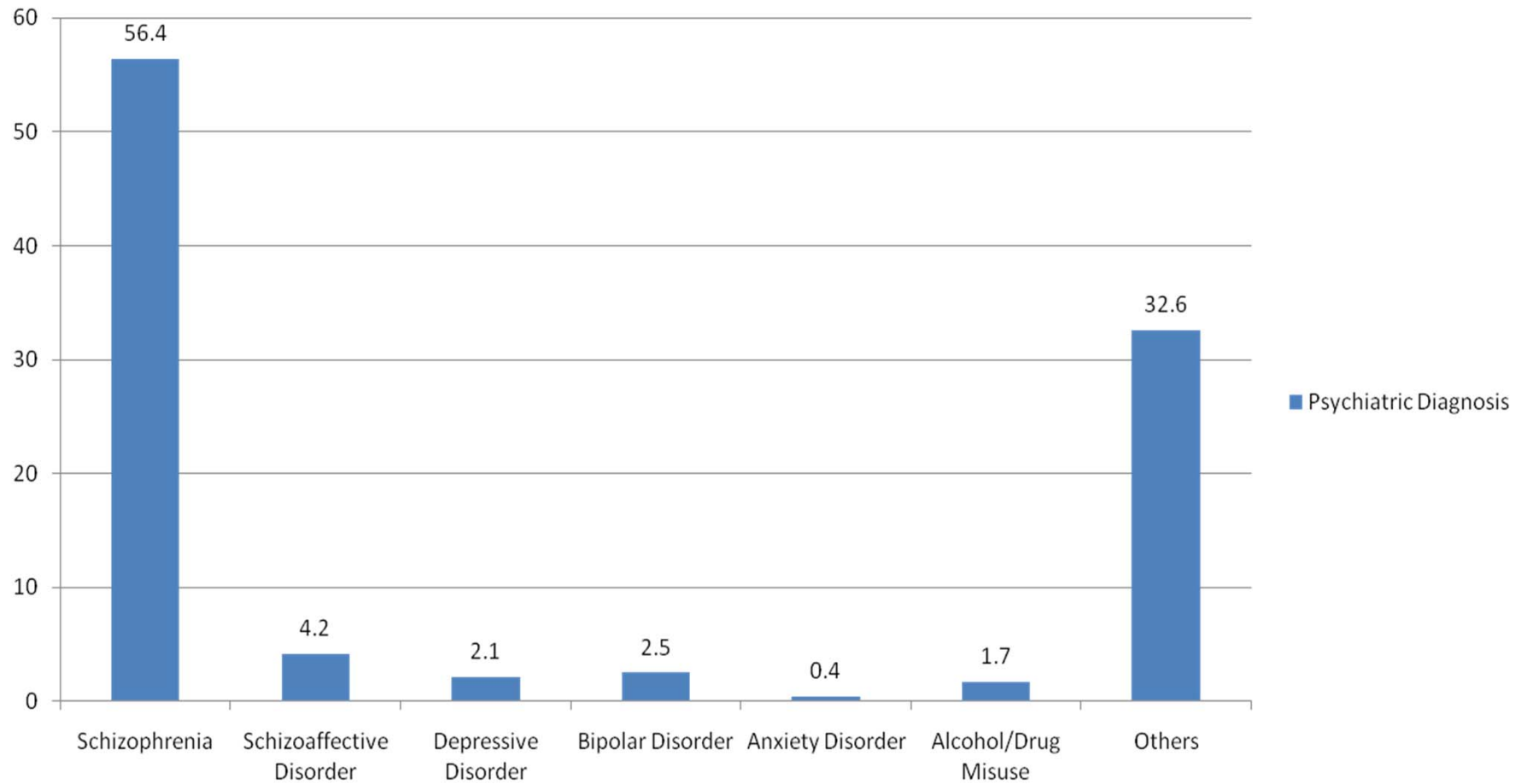
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## Gender





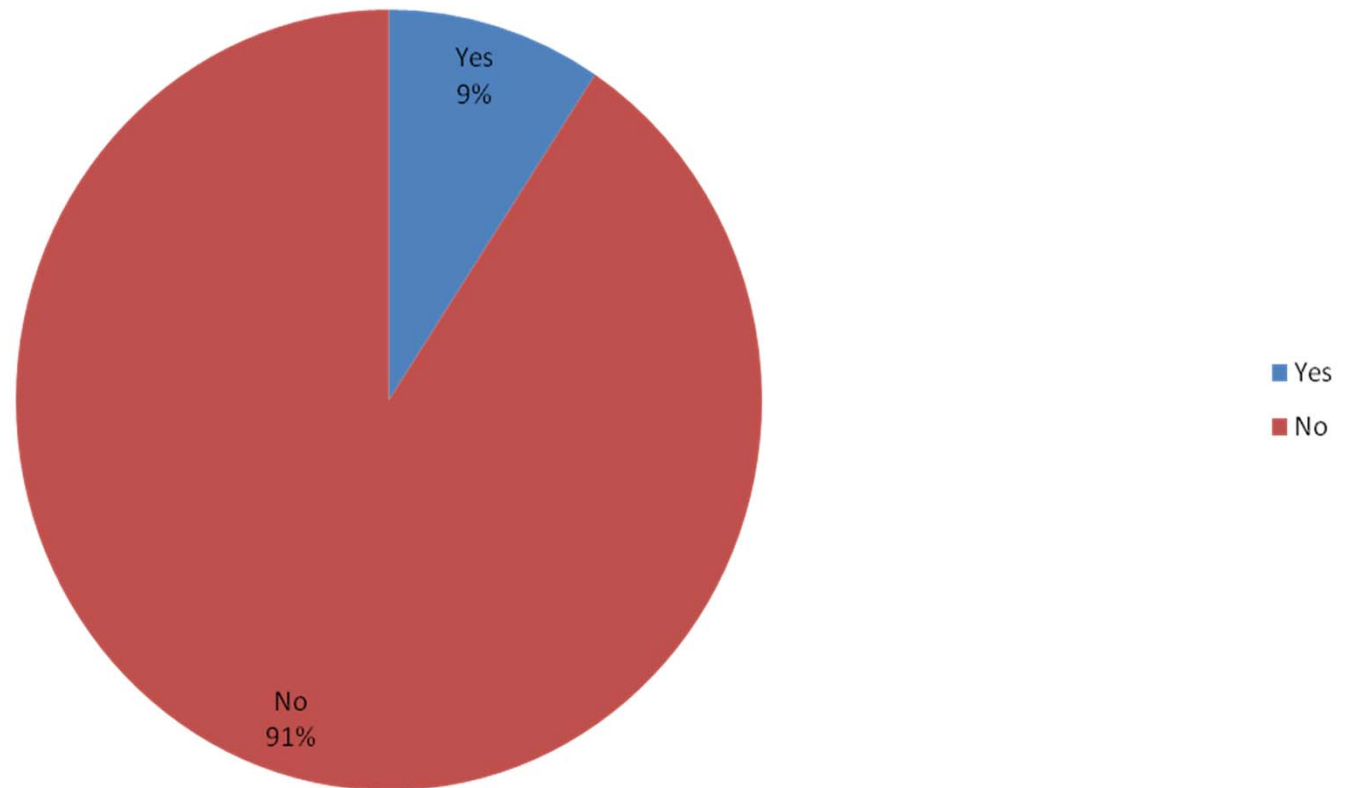
## Psychiatric Diagnosis





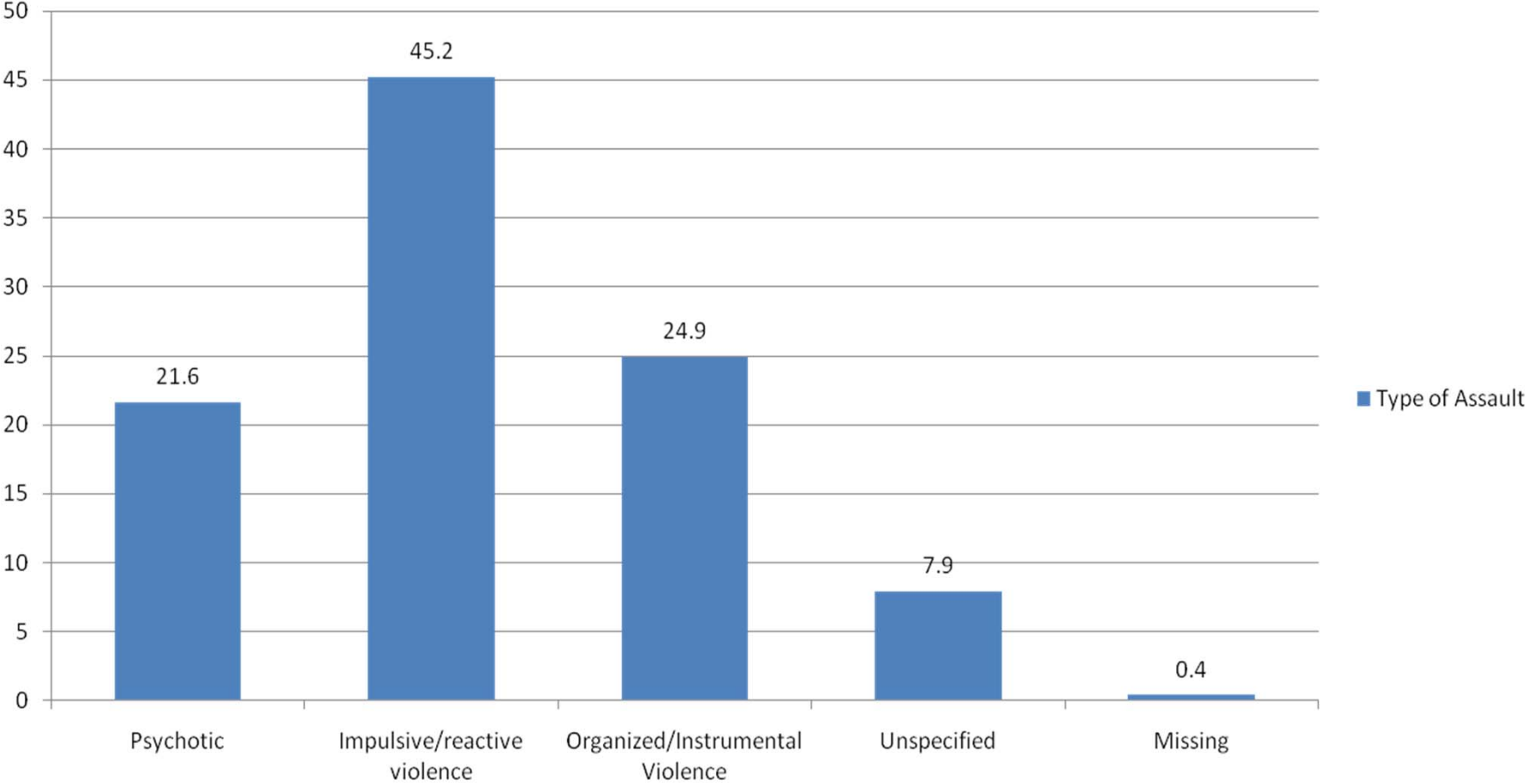
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## Comorbid Antisocial Personality Disorder





### Type of Assault





# Implications for response and prevention

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- About half the assaults are “reactive” in nature and often preceded by argument, conflict/ fight, perceived provocation, or sometimes in the context of restraints
  - Scope for early interventions – de-escalation, graded responses to varying levels of arousal
  - Empirical basis for Fremantle approach in our setting
  - Interventions/ Medications



# Implications for response and prevention

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- About a quarter of the assaults are “instrumental”
  - Certain personality traits, past history of violence are important to note
  - But only 9% has a chart diagnosis of ASPD/ traits



# Implications for response and prevention

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- One fifth of assaults can be attributed to psychotic factors
- Positive symptoms of schizophrenia have been associated with aggressive behaviour (Swanson et al., 2006)
- High levels of psychotic symptoms are associated with increased aggression, in inpatient setting (McNiel et al., 2003)
- Scope for psychiatric treatment - reducing risk
- IMH's High-Dependency Unit



# What do we know about violence?

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- Multi-faceted
- Contextual
- Risk factors



## Nolan et al (2003)

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- Ward for aggressive inpatients
- 36 non-staff victims; staff members were victims in ten incidents.
- 20% related to +ve psychotic symptoms, 80% impulsive or 'psychopathic'



## Quanbeck 2007 (continued)

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- 1190-bed LT-care psychiatric facility,  $\pm$  80% forensic, 20% civil commitment
- Most patients had a primary psychotic disorder
- Most common type of assault was impulsive (54%)
- Less frequently, organized (29%) and psychotic (17%) assaults



# Violence risk - SCAVR tools

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- HCR-20
- PCL-R
- \* START
- \*\*SAPROF



## SCAVR tools – uses and limitations

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- \* Findings concerning community violence and its predictors may not be generalizable to the prediction of inpatient violence.
- Variables such as gender, age and diagnosis and even substance abuse have limited usefulness in predicting inpatient violence.



## SCAVR tools – uses and limitations

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- “The best predictor of inpatient violence probably is previous violence. Further moderate good predictors are psychopathological state and ward environment.” (Steinert, T. 2002)
- \*\*The accuracy of clinical predictions of inpatient violence is better than chance but limited by the effects of therapeutic interventions.

# Beyond HCR-20 : Advert for new forensic CM?

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***“If you possess these skills, we want you!”***

# High-risk settings?

Community  
Mental Health





# Vulnerable staff

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- ❑ NO ONE IS IMMUNE
- ❑ Work alone or in small groups
- ❑ Late night or early morning hours
- ❑ Community settings

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- ❑ Zero-tolerance policy toward workplace violence against their employees.



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□ Secure the workplace





# Home visits

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- Develop policies and procedures covering visits by community mental health staff
  - How home visits are conducted.
  - Presence of others in the home during visits.
  - Staff's right to refuse to provide services in a clearly hazardous situation.
  - Not to enter any location where they feel unsafe.
  - “Buddy system”/escort or police assistance in potentially dangerous situations.



# Home visits

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- Equip staff with cellular phones and hand-held alarms or noise devices
- Require staff to prepare a daily work plan and keep a contact person informed of their location throughout the day. (FIPTS)



# Safety education for staff

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- ❑ What conduct is not acceptable
- ❑ What to do if they witness or are subjected to workplace violence
- ❑ How to protect themselves
- ❑ (De-escalation and Restraint techniques)



# “Environmental” factors

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- ❑ Overstimulation
- ❑ Overcrowding
- ❑ Inadequate facilities
- ❑ Lack of channels for communication



## “Environmental” factors:

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- ❑ Confrontation/ unreasonable pattern of communication
- ❑ Poor reporting/ communication skills
- ❑ Failure to act on communication received
- ❑ Lack of cohesion/ leadership
- ❑ Inadequate staff resources



# Aggressor types

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- “Normal”
- “Organic”
  - Intoxication with alcohol or drug abuse
  - Diseases of the brain e.g. head trauma, infection, dementias
- Psychotic
- Antisocial / borderline personality
- Procriminal attitudes or poor impulse control



# Potential triggers:

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- ❑ Requests not granted
- ❑ Refusal to comply with staff requests
- ❑ Disagreement



# Recognise when potential aggressors are aroused - Verbal Cues:

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- Verbal Threats
- Ritualistic repetition
- Depersonalizing language



# Recognise when potential aggressors are aroused – Non-verbal cues

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- Agitation, restlessness, frequent movements
- Threatening gestures, provocative behaviour
- Holding the gaze in a confrontational way
- Invasion of personal space
- Banging tables and throwing chairs
- Clenched fist/ obvious facial muscle tension
- Poking, pointing fingers or pushing
- Towering posture
- Unusual or inconsistent behaviour



# The Assault Cycle

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- Baseline Behaviour
- Trigger Phase
- Escalation Phase
- Crisis Phase
- Recovery Phase
- Post-crisis Depression Phase



# Verbal and Non-verbal Responses to Aggression


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- ❑ Not try too hard to engage potential aggressor
- ❑ Friendly, concerned and sympathetic
- ❑ Separation of parties involved
- ❑ Manage others in the environment
- ❑ Encourage thought – How? When? But not “Why?”
- ❑ Give clear instructions, negotiate options
- ❑ Eye contact and posture

**It's Not Physical...**

**IT'S ALL** I OUGHT TO SEND YOU AWAY!  
**YOUR FAULT!** HOW COME YOU'RE SO STUPID?  
WHY ARE YOU **YOU'RE UGLY**  
SO NEEDY?  
**YOU** **NOBODY COULD EVER LOVE YOU!**  
**IDIOT!**  
**YOU'RE A MISTAKE**  
WHY CAN'T YOU DO ANYTHING RIGHT?  
**I WISH YOU** **HURRY UP YOU**  
**MISERABLE**  
**Shut up!** **WERE BRAT!**  
**GET OUT OF** **DEAD**  
**MY FACE** **YOU MADE ME SAY IT!**





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Evidence Based Nursing -  
Management of Disturbed,  
Aggressive and Violent  
Behaviours in  
Inpatient Mental Health Settings



# Modified Fremantle Scale

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- Unstructured assessment and de-escalation techniques by nurses might have led to physical aggression.
- Evidence from the literature supports the use of strategies such as interpersonal skills training, skilled supervision and de-escalation techniques.
- This has reduced the seclusion rate of highly volatile patients by up to 50% since implementing it in 2006.



# Modified Fremantle Scale in IMH

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- ❑ Piloted MFS from Dec 2008 to Feb 2009
- ❑ Rolled out MFS in all wards in April 2009
- ❑ Guide for nurses to assess the patient's level of agitation and the appropriate psychosocial interventions to implement at each level.



# Modified Fremantle Scale

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- Nursing interventions (de-escalation, ventilation, redirection, time-out)
- Oral rapid tranquilization (RT) ->  
Intramuscular RT
- Physical restraint



# Modified Fremantle Scale

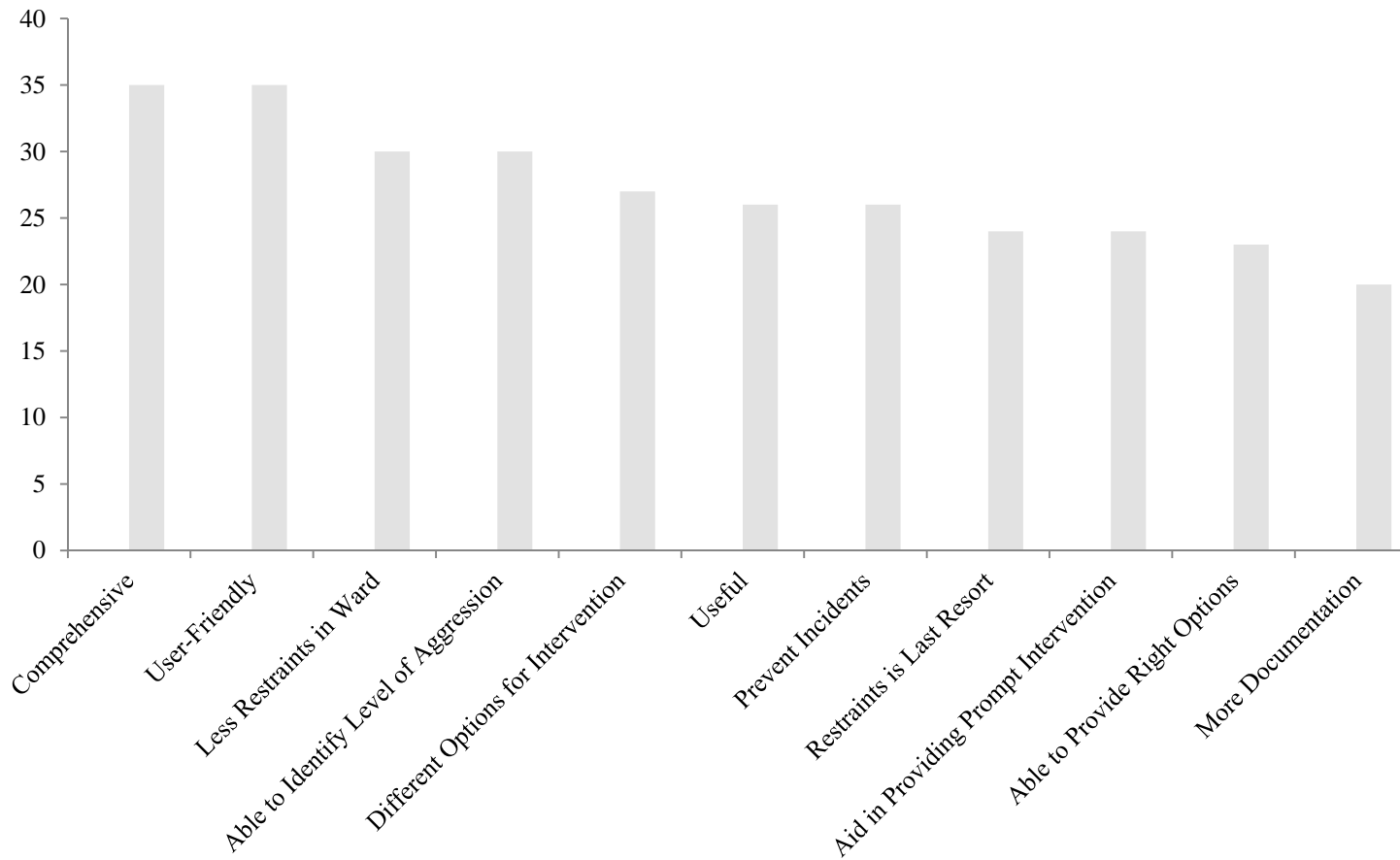
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- ❑ Positive results with regards to restraint episodes.
- ❑ Nurses' feedback - comprehensive, user-friendly, allows for different options for early intervention and even help them in identifying the level of aggression and to act promptly.

## The Modified Fremantle Acute Arousal Scale and Psychosocial Interventions

Description	Level	Intervention	Description
Calm or sedated	<b>0</b>	<b>Continue monitoring</b>	Vital signs and mental state when awake
Settled, minimal agitation	<b>1</b>	<b>Ventilation</b>	Create opportunities for the patient to express fears, frustration anger, anxiety and triggers
Mildly aroused, pacing, still willing to talk reasonably	<b>2</b>	<b>Redirection</b>	Explore with the patient solutions that would assist them to gain control, specifically distraction techniques that may be of use. These may include, thought stopping, attending a group, or listening to music
Moderately aroused, agitated, becoming more vocal and unreasonable or hostile	<b>3</b>	<b>Time-Out</b>	Patient requests or is asked to go voluntarily to an area to spend a specific period of time away from others (Morales, 1995); reflect upon stressor; relaxation techniques.
Highly aroused and possibly distressed or fearful	<b>4</b>	<b>Rapid Tranquillization</b>	PRN PO or IM psychotropic and/or benzodiazepine.
Highly aroused, violent toward self, others or property	<b>5</b>	<b>Restraint</b>	Being held against active resistance by physical or mechanical means (Paterson et al, 2003)

# Staff feedback on Fremantle Acute Arousal Scale & Psychosocial Interventions





# Following incident of workplace violence

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- ❑ Encourage staff to report all incidents and threats of workplace violence.
- ❑ Provide prompt medical evaluation and treatment after the incident.
- ❑ Report violent incidents to the local police promptly.
- ❑ Inform victims of their legal right to prosecute perpetrators.
- ❑ Discuss the circumstances of the incident with staff members. Encourage employees to share information about ways to avoid similar situations in the future.



# Following incident of workplace violence

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- ❑ Offer stress debriefing sessions and posttraumatic counseling services to help workers recover from a violent incident.
- ❑ Investigate all violent incidents and threats, monitor trends in violent incidents by type or circumstance, and institute corrective actions.
- ❑ Discuss changes in the program during regular employee meetings.



# Quality Improvement Processes

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- ❑ Root Cause Analysis (Post-incident)
- ❑ Failure Mode Event Analysis
- ❑ Clinical risk management
- ❑ Safety walkabouts



# Quality Improvement Processes

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- Important to have culture of safety:
  - Report all incidents immediately (eHORs)
  - Recognize potentially violent situations
  - Raise alert on any concerns about safety or security and report

THANK YOU

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