

Managing aggression in the emergency department: Promoting an interdisciplinary approach

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Abstract Incidents of aggression are frequent occurrences in hospitals, particularly the emergency department. Aggression creates instability in the environment, impacts on patient care outcomes and leads to increased levels of stress in staff. Regular exposure to aggression in the workplace can have detrimental effects on health professionals' ongoing quality of life. The emergency department is a gateway to care and is heavily populated 24 h a day. Therefore, it is essential that all health professionals are confident and well prepared to manage aggression.

Based upon a review of the literature this paper outlines the causes of aggression and provides an interdisciplinary action plan for intervening with aggressive patients in the emergency department. The importance of interdisciplinary ownership and the well planned management of aggression are outlined.

When well managed, the impact of aggression can be limited. Stability in the emergency department ensures that health professionals can be responsive to the community's needs for emergency care. This leads to the provision of effective and timely care and a stable work environment for all health professionals.

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Introduction

Globally, violence and aggression are increasing with wars, conflict, assault and antisocial behaviour being widely reported by the media. Terrorism has become part of our everyday lives and violence has its own descriptors, for

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example, "domestic violence" or "racial violence" to make it appertain to groups in society. Aggression and violence have also found a way into the health care environment with health professionals now being exposed to the overt and covert dangers of violence and aggression on a daily basis.

According to Hislop and Melby (2003) the words violence and aggression are often used interchangeably but for the purpose of this paper the word aggression will be used. Aggression is defined as "animosity or hostility shown towards another person as a response to frustration or opposition" (Burr et al., 1998, p. 13) or as "domineering, forceful or assaultive verbal or physical action toward another person" (Stedman Medical Dictionary, 1995, p. 37). However, in the health care setting, aggression is often a less clearly defined concept (Jones and Lyneham, 2001) that encompasses behaviours ranging from verbal threats and rude gestures to physical attacks including punching, kicking and biting (New South Wales Emergency Nurses Association, 2001). All forms of aggression have the potential to impact significantly on the well-being of health professionals (McGowan et al., 1999). While a comprehensive review of the literature identified that well established aggression management pathways were established in the mental health setting, such pathways were not common place within the emergency department.

Background

The emergency department (ED) is a gateway to health care for a large percentage of the population and as a result the constant exposure of staff to the public leaves them vulnerable to abuse and their safety frequently at risk. Kennedy (2005) asserted that health professionals working in the ED were exposed to aggression on a daily basis and that concerted action and immediate attention was warranted to address the problem. Internationally, statistics show that over 30% of assaults on health professionals in the United Kingdom were directed towards ED staff (Winstanley and Whittington, 2004). These authors attributed the high rate of assaults on staff to the 24 h, seven days per week interface staff working in the ED have with the community.

Successful management of aggression in the ED requires urgent and consistent attention with an underlying philosophy that all health professionals accept responsibility for assessing, responding to and managing aggression when it occurs. However, health professionals historically have not demonstrated a unified approach to managing incidents of aggression with nursing and security staff frequently left to manage the aggressive incident (Kennedy, 2005). The attitude that aggression is an unavoidable and necessary "part of the job" not requiring any formalised interdisciplinary response appears to be central to this approach (Crilly et al., 2004; Emergency Nurses Association, 2001; Jones and Lyneham, 2001). As a result, aggressive incidents often go unreported and the individual who managed the incident does not seek formal organisational support to manage their feelings of stress and anxiety. Jones and Lyneham (2001) described this as the hidden aspect of emergency work and incidents are not reported because the health professional fears being labelled and stigmatised as

being "weak or not tough enough" to work in the ED (Hislop and Melby, 2003; Jones and Lyneham, 2001; Kennedy, 2005).

It is well recognised that continual exposure to aggression has a significant impact on the individual and their family/significant others. It has been linked to increased drug and alcohol misuse/abuse, the development of post traumatic stress disorder, the need to take sick leave and reduced levels of work performance and job satisfaction (Jackson et al., 2002). The impact of aggression is a major reason as to why many nurses leave the profession (Ferns, 2005; Gates et al., 2005). For families and/or significant others the impact of managing aggression is transferred by the staff member into their lives, for example, in the form of relationship breakdown, financial hardship and increased levels of family dysfunction and stress (Jackson et al., 2002).

Aggression also spills over onto the lives of other patients in the ED. In an already uncertain environment, being involved in an aggressive incident may exacerbate or prolong their presenting problems. These patients may also become defensive and this instability further distracts staff from their routine work. It leads to increased waiting times and frustration levels in those forced to experience delays in receiving medical and nursing attention. A vicious circle is commenced which delays patient discharge and blocks beds in the ED (Crilly et al., 2004). To limit the impact on the ED environment each patient displaying aggression must be quickly and accurately assessed by the interdisciplinary team to identify the cause of the presenting behaviour and facilitate a well planned resolution.

Causes of aggression

Patients display aggression for a variety of reasons. For some it is a planned, calculated behavioural response to achieve a desired goal in a given situation, for example, to bully or coerce others (Crilly et al., 2004). As a patient in the ED they may resort to this interactional style to achieve personal rewards and 'positive' results (Hislop and Melby 2003) and they pose a significant challenge and threat to ED staff. Their aggressive behaviour is often pre-meditated and goal directed and may make the process of diagnosing other underlying presenting problems difficult. Managing these patients may pose a risk to the personal safety of the staff member and creates a situation that may lead to mistakes being made in the assessment of crucial information about the patient's presenting illness.

A patient's aggressive behaviour is often a symptom of an underlying medical problem, for example, hypoxia, delirium, adverse drug reaction, head injury, infection, cerebral irritation or hypoglycaemia. In addition, withdrawal from alcohol and drugs can all precipitate an altered mental state which often leads the patient to display aggressive behavioural changes. Patients who are in pain may also display aggression. In addition, substance misuse has regularly been identified as a cause of aggression and the rate of presentations of this patient population is increasing (Crilly et al., 2004). Baskin-Sommers and Sommers (2006) reported that methamphetamine was a powerful addictive stimulant that dramatically affects the central nervous system leading to

patient presentations of aggressive and psychotic behaviour. The majority of patients using methamphetamines are males with a mean age of 23 years and their behaviour is largely poorly managed within the ED by a predominantly female health profession population (Baskin-Sommers and Sommers, 2006).

It is also estimated that 40% of aggressive incidents in the ED were precipitated by people with mental health problems/illness (Kerrison and Chapman, 2007). Many of these patients have a combined general medical and psychiatric illness, recent trauma, substance use and substance related conditions, and cognitive impairment disorders (Wynaden et al., 2003). If not promptly assessed and managed their behaviour may quickly escalate in an ED environment which is highly populated, noisy, well lit, and offers little privacy and sense of security.

Managing aggression requires an interdisciplinary approach

Interdisciplinary management of aggression in the ED should be supported by a clearly articulated management plan. All health professionals groups must be well educated and competent to manage aggression, de-escalate difficult situations and be able to use breakaway techniques, which are methods to escape from a perpetrator using minimal physical force. These techniques are intended for any person regardless of physical strength. Annual workplace compe-

tency evaluations can ensure this level of compliance. Furthermore, all ED staff should be skilled in the areas of physical, cognitive and mental status assessments to facilitate quick and accurate identification of the cause of aggression (Kerrison and Chapman, 2007). To ensure that aggression is managed in a systematic way a predetermined number of health professionals assigned to the shift must be allocated to an aggression management team (AMT) (Crilly et al., 2004). This ensures all ED staff gain experience and develop confidence to respond to aggressive incidents. The team should include a minimum of five personnel and must include a senior doctor, at least two nurses, and possibly security officers and patient care assistants (P.C.A.) (NB, some hospitals may not have security officers or P.C.A.). The doctor will take on the role of team leader and facilitate the decisions around management of the incident. The nurses will prepare medication as per hospital policy when required, and assist in the restraint process; security officers and P.C.A. staff will assist in the physical restraint process by immobilising the aggressor by each holding down a limb. The management plan consists of three main stages: (1) Recognition and Assessment of Aggression, followed by de-escalation; (2) Physical Restraint; (3) Chemical Restraint. However, it is important to reinforce that the management is not a linear process and not all steps will be utilised to manage each aggressive incident. These stages are discussed further below and illustrated in Diagram 1.

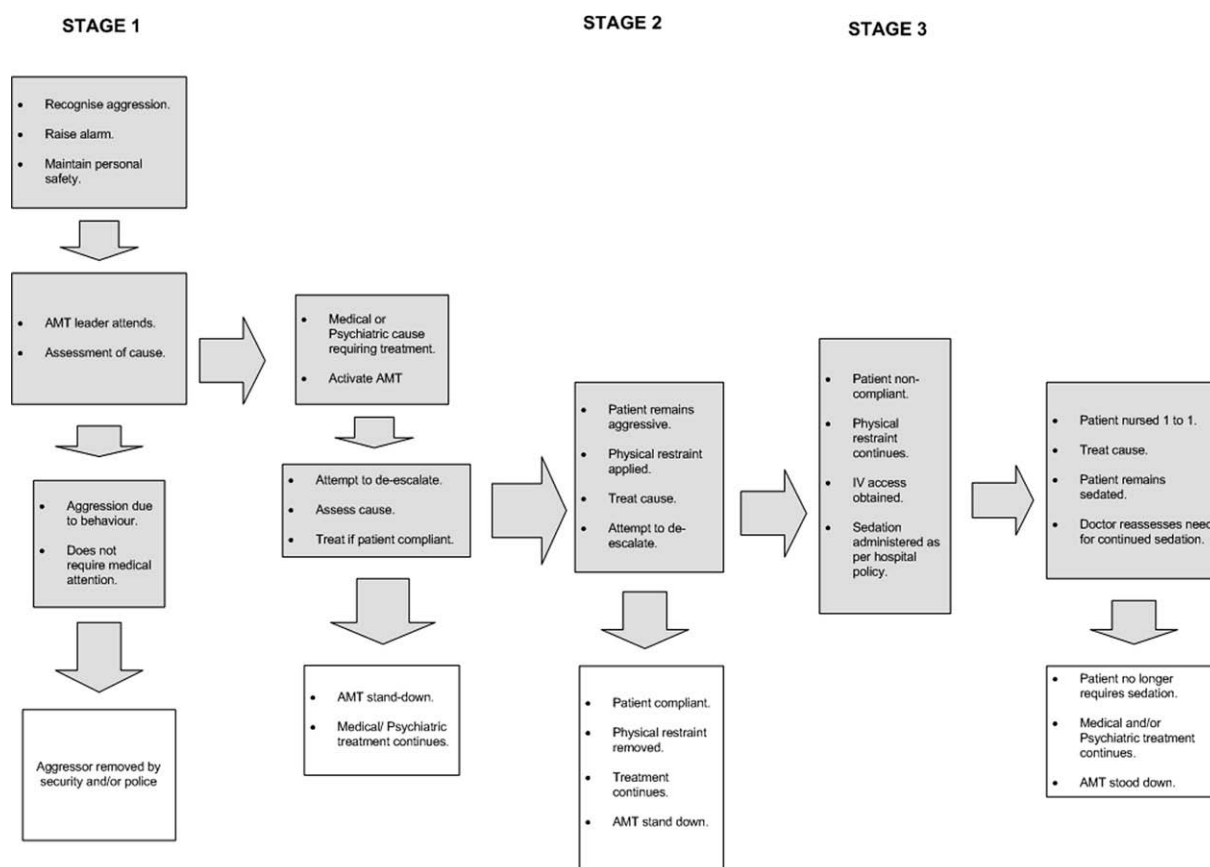


Diagram 1 Flowchart to illustrate 3 stages of aggression management.

Stage 1: recognition and assessment of aggression, and de-escalation

On recognition of potential or actual aggression the alarm is raised by either telephoning switchboard to page the members of the AMT, (some establishments may have an emergency procedure for this matter, for example a "code black"), or if this is not possible activating silent or personal alarms. The Aggression Management Team (AMT) assemble and the leader attends the scene to make a rapid assessment of the situation and to determine if the aggression is due to behaviour or a medical cause.

The team leader should attempt to de-escalate the situation by talking with the patient and emphasising the need for them to gain control over their behaviour. The team leader should also try to find out why the person is behaving aggressively and deal with this. Often the cause of aggression can be due to a perceived lack of information, concern for a relative, or the need for reassurance etc.

If required medical treatment will be instigated at this point, for example administering glucose if a patient is hypoglycaemic, then further assessment of the patient's cognitive state can be made, along with obtaining valuable information from relatives and medical records. If the team leader assesses that the person's aggression is not caused by a medical condition they should contact security staff to assist in the management of the patient. In some circumstances this may require the help of police to remove the aggressor from the ED.

If the leader assesses that the patient's aggression is due to a psychiatric issue, an urgent referral should be made to the Emergency Department Psychiatric Liaison (EDPL) staff if available or other similar psychiatric referral to instigate psychiatric care. If the patient has combined causes of aggression i.e. medical and psychiatric he should be treated by both specialties and Stage 2 of the management plan is activated.

Stage 2: further de-escalation and physical restraint

The team leader should continue attempts to de-escalate the situation whenever possible. If this is done successfully the patient will remain in ED to receive medical treatment and the AMT can be stood down. If the patient does not respond to the continued de-escalation attempt, the team leader may order the use of physical restraint. This would be a five person exercise with one person controlling the head and the other four personnel taking a limb each, however in some cases there may need to be extra people to hand as sometimes the aggressor will be resistant and require more physical effort to restrain him. As some patients may not be able to respond to staff due to their underlying medical problem it is important that while physical restraint is being implemented the patient is kept informed of what is happening. The team leader must continue to try to de-escalate the situation and gain the patient's trust and support to reduce the need for restraint. If this is unsuccessful and the patient does not calm down whilst being physically restrained so that further medical treatment can be given, it may be necessary to move to Stage 3 of the management

plan; this stage should be as a last resort when all efforts to defuse the situation have been made.

Stage 3: chemical restraint

With the patient physically restrained the team leader will continue to try to de-escalate the situation while sedative medication is prepared as per hospital policy, and given intravenously by a doctor. Following administration of the sedative the patient must be specialised by a nurse. The doctor and nurse should regularly reassess the patient to make the sedation period as brief as possible. The patient should then be referred to an appropriate team of doctors who will admit the patient to hospital, and continue their management. The AMT should then be stood down.

Stand-down, and staff well-being

As soon as the incident is over the team leader should assess the well-being of the all members of the team as well as other patients in the area. Assessment of the mental and physical health of staff involved should occur and debriefing and treatment procedures initiated if required. The incident should be reported to management and documented using established hospital policies and procedures. The report should be followed up by hospital management and, if necessary, recommendations made from their findings.

Reporting is a valuable assessment tool, and can play an important role in quality improvement in managing aggressive patients within the ED environment.

Discussion

The management of aggression in the ED is of strategic importance to the delivery of timely quality care to all patients and their families. All members of the interdisciplinary team are responsible for maintaining a therapeutic ED environment, therefore, they need to be educated and feel confident to manage aggression when it occurs. Interdisciplinary ownership of aggression will ensure accurate and prompt assessment, identification of the cause of aggression and safe and consistent management of aggressive patients within the ED. It is recommended that where a policy for an AMT exists the team is pre-allocated at the beginning of each shift with pre-defined roles to avoid confusion when an aggressive incident occurs. Strategies for managing aggression should be given the same priority as the management of other critical events, for example, resuscitation.

As the ED is a gateway to care for a large percentage of the vulnerable section of our community staff need to have confidence and skills to work with patients who may display aggression as part of a larger problem, for example, physical and mental illness or patients who become frustrated more easily or may use aggression to obtain their desired outcomes. Intervening early with these patients or members of the public before the aggressive behaviour escalates will facilitate positive outcomes for both patients and staff. The intervention must include options that allow the person to control their aggression without "losing face". De-escalation is the preferred outcome and the first line of intervention. It is an important therapeutic process to help counter

the growing issue of aggression (Cowin et al., 2003). It should be attempted several times and precedes the activation of other interventions used by the aggression management team, including physical and chemical restraint.

ED staff should be trained and be confident in the use of de-escalation techniques and this education needs to be embedded in the culture of the department. Mentoring and support of all new staff will ensure that this culture is maintained on an ongoing basis. Education should include hands-on demonstration and practice in de-escalation techniques, crisis intervention techniques, physical restraint practice, and training in breakaway technique for escaping a perpetrator. The use of role play will facilitate opportunities for less experienced staff to become familiar with practices and language used in these situations. Education should also include the assessment and use of pharmacological agents used in chemical restraint to promote safe administration and optimal patient care. The use of education programs is supported in the literature with researchers claiming that adults learn from practice far more than they do from listening to someone talking (Farrell and Cubit, 2005; The United Kingdom Central Council for Nursing and Midwifery, 2003). Aggression management drills should be practiced as often as resuscitation, and become part of emergency procedure training. Internationally, hospitals recognise medical emergencies as "code blue" and incidents of aggression should be recognised in a similar manner.

The maintenance of personal safety is always a priority for staff and they should never put themselves or others at risk. Early recognition of the potential for aggression, the raising of the alarm and summoning help is vital and an important skill for ED staff to possess. If there is a weapon involved the police/ security teams should be immediately called to assist in managing the incident regardless of the cause.

If an aggressive patient is required to remain in ED for treatment the process requires ongoing multidisciplinary assessment and re-evaluation of aggression. Chemical restraint practices need to be reviewed and prompt referral to appropriate health professionals be made to limit the length of time a patient is sedated. This will result in optimal outcome for the patient, and limit the impact on the ED environment. Chemical restraint used in line with specific hospital policies involves one-to-one nursing to ensure the patient's safety and ongoing management while they are sedated. Prompt assessment by other health professionals during this time will limit the time the patient is chemically restrained and ensure appropriate follow up care is provided.

The process identifies a three stage approach to managing aggressive patients which ultimately arrive at the same destination; the patient is managed safely and appropriately in the ED environment. While physical and chemical restraint may be viewed as the last resort they are often necessary to safely manage difficult patients and minimise risk to the patient, ones self and others. The length of time that restraint is used needs to be minimised with constant re-evaluation by all health professionals. This will ensure that the patient receives appropriate management of their medical condition and that the safety of the ED environment is maintained.

The final stage of the management pathway is based on the well-being of the health professional, it advocates that all aggression be reported and recorded, it encourages staff to own the problem and if feedback is given when the report is lodged the staff will be more likely to feel that something is being done to address the issue, and that their voices are being heard by their managers. It will begin to dispel the myth that aggression is just "part of the job" (Crilly et al., 2004).

Debriefing is an important part of the process of managing aggression. Aggression is a critical incident and such incidents and can cause disruption to people's lives and create strong emotional reactions that have potential to interfere with their ability to function either at the time or later on (Mitchell et al., 2003). The purpose of debriefing allows staff to manage their stress response to abnormal situations. It should be offered on a group or individual basis with the opportunity of referral for further counselling. However, it should not be forced on each individual as not everyone is comfortable with the process.

Conclusion

The management plan described in this article has been developed following an extensive review of the literature in this area and following formal discussions with clinical ED staff. Many components of the process are based on global best practice and proven to be effective in a variety of situations. As aggression impacts on the ED in a variety of ways it is important that all incidents are quickly managed and the cause of the patient's aggression promptly assessed. Effective management of aggression facilitates an ED environment where staff are free to deliver a high standard of health care within a safe and secure workplace.

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