MANAGEMENT OF VIOLENT & AGGRESSIVE BEHAVIOUR
Self-directed learning package

Name: ____________________________________
Belmore ID: _____________________________
Date: _________________________________
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Appendix

- Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria’s mental health services
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INTRODUCTION

Aggressive behaviour in the workplace is a serious and complex issue that affects individuals, organisations, governments and the wider community. Nurses have been identified as the group most at risk of occupational violence in Australia, and many nurses experience repeated acts of verbal and physical aggression in the workplace. The real size of the problem is unknown due to underreporting by nurses, indicating that they believe it is just part of the job. “Nurses and midwives have the right to work in a safe and healthy workplace free from violence and aggression. Aggressive and violent behaviour toward nurses and midwives is unacceptable and should not be tolerated in any workplace” (ANF, 2008).

Despite this, evidence suggests that two thirds of nurses will experience various forms of workplace aggression each year (Mayhew & Chappell, 2003). The source of violence and aggression can be any person including patients, visitors, and work colleagues. Violence and Aggression perpetrated by work colleagues, for example workplace bullying and harassment is not within the scope of this package. Please refer to specific facility policies or the ‘Discrimination, Bullying, Workplace Violence and Harassment Policy – P007’ available from Belmore for more information on these issues.

This learning package provides a framework for the identification, prevention and management of aggressive behaviour in the health care setting. The primary focus is on patient based aggression, however the strategies and approaches described are also suitable for aggression by family members/visitors and the general public. The key resources used to compile this package were sourced from organisations that represent workers and employers. These include Worksafe, Department of Human Services (DHS) and the Australian Nursing Federation (ANF).

In addition to the information provided in this package, questions have been included for further learning and reflection. Once you have completed the package, you should have a greater understanding of the factors involved in aggressive behaviour, incident prevention, practical approaches to managing aggressive behaviour and post incident response.

**Instructions for package completion**

This self-directed learning package has been developed to provide basic information in regards to dealing with violent or aggressive patients. It is designed to be a starting point for your learning. It is expected that you will refer to other resources for more information. Some suggested resources include but are not limited to:

- Facility clinical guidelines and protocols
- Textbooks
- Journal articles
- Online resources

It is suggested that you work through each of the sections, reading the information before performing activities or answering the questions.
Answers to the questions can be accessed once your package is completed by contacting Belmore on 8873 4515.

**LEARNING INTENTIONS & OUTCOMES**

The aim of this package is to provide guidance material for Belmore Nurses Bureau employees regarding assessment, prevention and management of aggressive behavior in the health care setting to ensure the safety of employees, patients and consumers.

Specific aims of this package are to:

- Increase awareness of employees regarding the issue of violence and aggression in the health care setting
- Provide information to ensure that employees comply with legislative frameworks and current industry standards
- Provide guidance material for the effective management of situations where violent/aggressive behaviour occurs or has the potential to occur
- Describe the process and procedure for the management of aggressive/violent behaviours in the health care setting
- Provide information that will facilitate the management of aggressive or violent behaviour to be carried out in a planned, safe and least disruptive manner
- Increase the skills and confidence of employees in managing patients exhibiting violent or aggressive behaviours
- Ensure respectful treatment of patients/clients exhibiting difficult behaviours
- Describe the process and procedure for reporting incidents of violence or aggression
- Outline the important phase of post incident debriefing

After reading this package and the relevant policies, you should be able to:

- Give examples of what constitutes occupational violence and aggression
- List the responsibilities of employees under the Occupational Health and Safety Act and the Belmore Nurses Bureau Occupational Health and Safety Policy
- Identify potential causes and triggers of violent or aggressive behaviour
- Describe the assessment and management of a person exhibiting violent or aggressive behaviour in the health care setting
- Explain when and how to initiate an emergency response Code grey/Code black
- Describe the roles of the Code grey team
- Interpret and apply the specific facility policy to situations of violent or aggressive behaviour
- Discuss the process of safe restraint application
- Discuss the care of a person post restraint application
- State the importance of debriefing and describe how to seek help/counselling post incident if required
Disclaimer

The information presented in this package was developed to support and assist Belmore Nurses Bureau employees to undertake professional development regarding management of aggressive or violent behaviour in the healthcare setting. Variations including policies and practices may occur and it is the individual staff member’s responsibility to be aware of the specific policies of each facility in which they work. This package does not include specific information about workplace bullying and harassment. Please see specific facility policies for more information on these issues.

The information provided is an overview. Further reading and study is recommended for more detailed explanation of the background and rationales for the care/management outlined.

This information does not constitute an exhaustive resource, or exclusive course of action. Care has been taken by the author to ensure the information included in this manual and resources used to compile it are accurate and up to date however, the author accepts no responsibility for any inaccuracies or the success of any recommendations detailed in the manual.

Any questions or points for clarification please contact the Education & Training Coordinator: education@belmorenurses.com.au

DEFINITIONS

‘Occupational violence and aggression’ is defined as “any incident in which an employee is abused, threatened, or assaulted in circumstances arising out of, or in the course of, their employment and includes: verbal, physical or psychological abuse; threats or other intimidating behaviours; physical attack, such as hitting, pinching or scratching; aggravated assault; threats with a weapon or objects; and sexual harassment and sexual assault” (ANF [Vic Branch] Zero Tolerance [Occupational Violence and Aggression] Policy, 2008).

‘Threat’ means “a statement or behaviour that causes a person to believe that they are in danger of being physically attacked, and may involve an actual or implied threat to safety, health or wellbeing” (DHS, 2007).

‘Physical attack’ means “a direct or indirect application of force by a person to the body of, or clothing or equipment worn by, another person, where that application creates a risk to health and safety” (DHS, 2007).

Further examples of workplace violence and aggression include (but are not limited to):

- Biting
- Punching
• Grabbing
• Tripping
• Pushing/shoving
• Throwing objects/furniture
• Aggravated assault
• Any form of indecent physical contact

“Exposure to aggression and violence in the workplace should NEVER be accepted as a normal part of the job.”

As a result of the increasing level of occupational violence and aggression against nurses and other health care workers, zero tolerance policies have been implemented.

‘Zero tolerance’ refers to the complete refusal to tolerate unacceptable workplace aggressive and violent behaviour. It is important to differentiate between these unacceptable aggressive behaviours and behaviour that arises as a result of an organic/medical condition. In these circumstances the emphasis is on prompt, compassionate clinical management of the patient while ensuring the safety of the patient, staff and others who may be affected by the behaviour exhibited.

According to the ANF’s zero tolerance of violence and aggression in the workplace policy (2008), Nurses and midwives have the right to:

a. be treated with respect;
b. be consulted on matters related to management of the risk of violence, including procedures, facility design, systems of work and equipment;
c. be informed of, and receive training in, policies, procedures, legal rights and responsibilities, services and resources available to assist staff to prevent and manage occupational violence and aggression;
d. make their own assessments of the degree of risk to themselves, and not put themselves at risk, even if directed to by their employer;
e. withdraw themselves to a safe area or defend themselves with the use of reasonable force if physically assaulted;
f. access to a health professional of choice for the purpose of recovery from the effects of occupational violence or aggression;
g. report threats, abuse and assaults to the police, and to be involved in any subsequent investigations and proceedings in the justice system;
h. workers’ compensation for any physical or psychological injury suffered as a result of occupational violence or aggression; and
i. rehabilitation and return to work so as to achieve the maximum possible functionality, activity and quality of life possible (ANF, 2008).
LEGISLATIVE FRAMEWORK

The Victorian Occupational Health and Safety Act 2004

The Victorian Occupational Health and Safety Act 2004 is the main legislation which deals with health, safety and welfare in the workplace. The objectives of the Act are to:

- Secure the health, safety and welfare of employees and other persons at work
- Eliminate, at the source, risks to the health, safety or welfare of employees and other persons at work
- Ensure that the health and safety of members of the public is not placed at risk by the conduct of undertakings by employers and self-employed persons
- Provide for the involvement of employees, employers, and organisations representing those persons, in the formulation and implementation of health, safety and welfare standards (DHS, 2005, p.18).

Employer responsibilities:

Under the Victorian Occupational Health and Safety Act 2004, employers are required to provide and maintain (so far as is reasonably practicable) a working environment that is safe and without risks to health, including the psychological health and welfare of employees. Under the legislation, this duty includes the provision of:

- A safe physical environment
- Safe systems of work
- Adequate facilities for the welfare of employees
- Information, instruction, training and supervision to enable employees to perform their work in a safe manner, without risks to health


Employee responsibilities:

Under the Victorian Occupational Health and Safety Act 2004, employees are required to:

- Follow workplace practices and policies that are designed to reduce occupational violence and aggression risk
- Report all incidents of occupational violence and aggression (to management of the healthcare facility and to Belmore Nurses Bureau)
- Identify, report and document all identified risks of occupational violence and aggression to management and other staff (e.g. during handover, by alert flagging in the patient’s history)
- Be alert to patient/visitor behavior and signs of escalation in order to minimise and avoid further escalation
- Take reasonable care for their own and colleagues health and safety at work by not knowingly putting themselves at risk of violence or aggression
• Refuse to work in a knowingly unsafe situation
  (DHS, 2005; The Parliament of Victoria: The Victorian Occupational Health and Safety
  Act, 2004; Worksafe Victoria, 2005).

More specifically, Belmore Nurses Bureau Occupational Health and Safety Policy states
that employees are required to:
• Comply with workplace health and safety instructions
• Take corrective action to eliminate hazards at work, or report those hazards which
cannot be immediately corrected
• Seek appropriate first aid or treatment for injuries and illnesses and report on the
appropriate form
• Use any personal protective equipment issued to you and maintain it in good
order
• Be familiar with emergency and evacuation procedures
• Not wilfully or recklessly interfere with or misuse any health and safety
equipment
• Not wilfully place at risk the health and safety of anyone at Belmore Nurses
Bureau
• Not wilfully injure themselves

Note: all accidents, incidents and “near misses” must be reported to your supervisor, the
health care facility and Belmore Nurses Bureau, even if they do not result in injury or
damage (Belmore Nurses Bureau, 2010).

*Also refer to specific facility policies and procedures.

The Accident Compensation Act 1985

The Accident Compensation Act 1985 is the legislation which deals with Victoria’s
WorkCover compensation system.
The objects of this Act are:
• To reduce the incidence of accidents and diseases in the workplace
• To make provision for the effective occupational rehabilitation of injured workers
  and their early return to work
• To increase the provision of suitable employment to workers who are injured to
  enable their early return to work
• To provide adequate and just compensation to injured workers
• To ensure workers compensation costs are contained so as to minimise the burden
  on Victorian businesses
• To establish incentives that are conducive to efficiency and discourage abuse
• To enhance flexibility in the system and allow adaptation to the particular needs of
disparate work situations
• To establish and maintain a fully-funded scheme
• To improve the health and safety of persons at work and reduce the social and economic costs to the Victorian community of accident compensation (DHS, 2005, p.19).

Employees are entitled to WorkCover benefits if they suffer a work-related injury or disease. The Accident Compensation Act 1985 states that all injuries must be reported within 30 days after you become aware of the injury. Under Section 102 (5) of the Accident Compensation Act 1985, an employee is not entitled to recover compensation under the Accident Compensation Act 1985 unless the injury was reported within 30 days. Please refer to ‘Reporting workplace injury and illness’ on page 11 for more information.

The Mental Health Act 1986

The Mental Health Act provides for the care, treatment and protection of mentally ill people. The Act has a rights orientated approach, and involuntary treatment must be associated with care and treatment. The individual has the right to liberty and to be treated with dignity and respect. Any interference with those rights must be kept to a minimum and can only occur when it is necessary for the treatment of the person or the protection of the community. Treatment must occur in the least restrictive environment, i.e. the least restrictive environment is being treated in the community as an informal patient (informal = voluntary), the most restrictive environment is detention in an inpatient unit as a security/involuntary patient.

The Act defines a mental illness as: “a person if mentally ill is he or she has a mental illness being a medical condition that is characterized by a significant disturbance of thought, mood, perception or memory” (The Parliament of Victoria, 2010: The Mental Health Act 1986, p.23). Mental illness is NOT refusal to express a particular political, religious, philosophical belief, sexual preference/orientation; engages in immoral or illegal conduct; takes alcohol or drugs; or has a particular cultural or economic status, intellectual disability or antisocial personality (The Parliament of Victoria, 2010: The Mental Health Act 1986).

Involuntary patients

Patients who are detained for treatment under the Mental Health Act 1986 are termed ‘involuntary patients’. Although incorrect, these patients are commonly referred to as ‘recommended’. Involuntary patients are generally not allowed to leave the ward/area without an escort (e.g. for cigarette privileges). In order to be detained as an involuntary patient, specific criteria detailed in the mental health act must be met. These are known as section 8 criteria:

1) The person appears to be mentally ill; and
2) The person’s mental illness requires immediate treatment and that treatment can only be obtained by the person being subject to an involuntary treatment order;
3) Because of the person’s mental illness, involuntary treatment is necessary for the health or safety (whether to prevent deterioration in the person’s physical or mental condition or otherwise) or for the protection of members of the public; and
4) The person has refused consent or is unable to consent to the necessary treatment for the mental illness;
5) The person cannot receive adequate treatment for the mental illness in a manner less restrictive manner of his/her freedom of decision and action. 

Involuntary status refers to people who meet the criteria of Section 8 of the Mental Health Act (1986), and have had a request and recommendation filled out (see page 11). In the event that an involuntary patient refuses treatment, treatment can be given against their wishes.

Voluntary patients
Voluntary mental health patients are seeking treatment of their own accord. They have the same rights to refuse treatment, and to leave the facility as do any other patient. However, if they decide to leave despite treatment for a mental illness being required, they may have to make them involuntary.

Patients initially may not be section 8 criteria as they consent to treatment however, often patients despite initially agreeing to treatment (thus appearing to have insight into their mental illness) change their minds and refuse treatment. When this occurs, often they are made involuntary.

Mental Health Paperwork
The following refers to paperwork most commonly completed in the ED setting:
- A request: can be filled out by anyone aged over 18 years, with the exception of the person filling in the recommendation (Section 9).
- A recommendation (section 9): must be filled out by a medical practitioner within the hospital.
- An Involuntary Treatment Order (ITO): made out by a medical practitioner in ED unless the person is to be transferred out of the facility (transfer requires Section 12AA).
  NOTE: within 24 hours of the ITO being made out, a Consultant psychiatrist must review the patient.

If you are caring for a patient that is involuntary, you must sight all relevant paperwork is completed and correct at the commencement of your shift.
REPORTING WORK RELATED INJURY & ILLNESS

All staff must ensure that they adhere to the Occupational Health & Safety Guidelines and practice in a safe and responsible manner. It is recognised that despite every effort by employers and employees to minimise risk, injuries or illness may still occur. Should you sustain a work related injury, you are entitled to submit a claim for compensation. You must follow protocol from the health care facility at which the injury is sustained and these steps must be followed:

- Stop working immediately and call for assistance if necessary
- Report the injury or illness to the immediate workplace Supervisor
- Get first aid treatment if necessary
- Ensure the workplace Supervisor documents details of the injury and obtain a copy of the incident report
- PHONE BELMORE AND REPORT THE INJURY (03) 98772533

Note: all accidents, incidents and “near misses” must be reported to your supervisor, the health care facility and Belmore Nurses Bureau, even if they do not result in injury or damage. In the event of an injury, you must obtain first aid treatment to ensure the injury does not get worse. All accidents, incidents and ‘near misses’ reported will be investigated to obtain the relevant facts to prevent further incidents of a similar nature occurring.

RISK ASSESSMENT

Frustration and anger arising out from illness, pain, psychiatric disorders, alcohol and substance abuse can affect behaviour and make people verbally or physically violent. Furthermore, many patients and relatives have uninformed and unrealistic expectations about what the public health service can and cannot deliver. People who are already facing a stressful situation when they face long delays, lack of communication or the care provided does not meet their expectations, may become aggressive.

Risk factors for aggression and violence can often be identified and assessed early, and strategies for prevention or defusion of the situation implemented. Being aware of these risk factors and hazard identification may prevent or significantly decrease episodes of aggression and violence, and ensure a safer work environment for all involved.

High risk areas

Some areas/departments have a higher risk of security incidents and potentially aggressive behaviours. Staff working in these areas are at a greater risk of aggressive or violent behaviour.
Emergency Departments
Increased risk to staff due to:
- Unpredictable environment
- Misunderstandings about what the public health system can and cannot deliver
- Frustration from long waiting times
- Providing care to a range of people who may be:
  - Afraid
  - Vulnerable
  - Distressed - patients and visitors
  - In volatile emotional situations/grief
  - Under the influence of alcohol and/or drugs
  - Exhibiting signs and symptoms of a mental illness
  - Suffering from dementia
  - Patients experiencing a delerium

Mental health services/facilities
Increased risk to staff due to:
- Certain psychiatric conditions may be associated with an increased likelihood of aggressive/violent behaviours, e.g. schizophrenia, schizoaffective disorder, personality disorder, co-morbid substance abuse
- Client cohort
- Overcrowding
- Inadequate staffing
- Substance misuse
- Boredom
- Delirium
- Lack of insight

Community nursing (e.g. home visits: Royal District Nursing Service [RDNS], Hospital in the Home [HITH], Outreach services, Home-based palliative care, CATT Team)
Increased risk to staff due to:
- Uncontrolled environment
- Nurses may be carrying drugs of addiction (i.e. palliative care) which may make them a target
- Night visits
- Responding to crisis situations

Maternity and Paediatric departments
Increased risk to staff due to:
- Volatile emotional situations
- Custody issues
- Child protection issues
- Family disputes/issue of domestic violence
- Cultural issues
- Misunderstandings/beliefs that care being provided is insufficient

**Intensive Care Units/Critical Care Units/Coronary Care Units**
Increased risk to staff due to:
- Highly stressful events
- Relatives may be dealing with grief/the imminent death of a loved one

**Pharmacy**
Increased risk to staff due to:
- Staff accessing and transporting drugs (particularly drugs of addiction)
- Individuals seeking drugs are likely to be drug affected or suffering symptoms of withdrawal

**Aged Care**
Increased risk to staff due to:
- Aggression resulting from changes in routine for the patient
- Patient disinhibition
- Dementia
- Patient anxiety
- Patient fear

**Disability Services**
Increased risk to staff due to:
- Aggression resulting from changes in routine for the patient
- Patient disinhibition
- Patient anxiety
- Patient fear
- Lack of insight

**Isolated work areas**
Increased risk to staff due to:
- Limited number of staff
- Work areas which are separate from main buildings
- Work areas which are located away from populated areas e.g. rural and remote services
- Parts of buildings which are separated from other populated areas

**Relative/Visitor specific situations**
Some specific situations have been identified that may prompt verbal abuse and aggression from relatives/visitors:
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- When staff do not respond immediately to a request for attention i.e. call bell, request for pain relief
- When relatives/visitors are refused admission or asked to leave when visiting hours are over
- When there are long waiting times in Emergency or Outpatient departments
- When appointments with health care specialists are been delayed or cancelled
- In paediatric wards when parents are fearful about the health of their child

**Hazard Identification**

Being aware of your environmental risk factors is vitally important should you find yourself in a position where your safety is compromised.

**Things to take note of at the commencement of your shift include:**

- Security personnel – presence, location, how to summons
- Entry and exit point options
- Physical layout and natural surveillance points
- Presence of objects that could be used as weapons
- Potentially dangerous building materials e.g. glass
- Areas of unrestricted movement of the general public e.g. cafeteria
- Poorly-lit areas of a facility
- Areas of limited access and exit
- Isolated or remote working locations

If, at any time, you have any queries or concerns about the safety aspects of your work, ask for clarification or contact either the Allocations Manager or Personnel Manager at Belmore Nurses Bureau.

**Risk Factors and Causes of Violent and Aggressive Behaviour**

Common factors/situations that may place staff at risk of occupational violence, aggressive or challenging behaviour include (but are not limited to):

**Patient/client related**

- Past history of:
  - Aggressive or violent behavior
  - Verbal abuse
  - Self harm
  - Substance abuse
  - Denial of previous dangerous acts
  - Antisocial behaviour
  - NB: this is why documentation/alert systems are vital
• Patients with acute and chronic mental health issues such as:
  o Psychosis
  o Paranoid delusions about others
  o Violent command hallucinations
  o Preoccupation with violent fantasies
  o Organic brain disorders
  o Schizophrenia
  o Bipolar disorders
  o Personality disorders
• Particular diagnostic group such as those with dual diagnosis (typically mental illness and substance misuse)
• Physiological imbalances or disturbances
• Uncomfortable physical conditions
• Pain, particularly if prolonged or untreated
• Recovering from unconsciousness e.g. post-operatively or following self-poisoning
• Situations where people are in distress or grief
• Situations where people are afraid
• Substance abuse/misuse (alcohol and drugs)
• Volatile emotional situations
• Family disputes
• Change in routine/sensitivity to disrupted routine (particularly in the dementia patient or those with intellectual disabilities)
• Disinhibition
• Confusion
• Dementia
• Anxiety
• Client cohort e.g., patients who are experiencing auditory hallucinations in a cubicle beside a patient in acute delirium, increased sensory stimulus
• Boredom
• Sensory overload e.g. ICU/ED
• Frustration, e.g. from:
  o Poor customer service
  o Long waiting times (answering the call-bell, treatment, Emergency Department waiting room)
  o Perception that someone is being denied service (e.g. if kept waiting)
  o Not being allowed to leave (e.g. involuntary patient)
  o Not being allowed to go outside for cigarettes (e.g. if patient is a flight risk, involuntary patient in the ED or staff unable to facilitate)
  o Delays in assessment, admission or transfer
• Forensic history
• Legal status of the patient (e.g. police custody)
• Presence of police (e.g. patient under arrest, section 10, awaiting treatment prior to questioning by police)
• Investigating and/or enforcing specific legal requirements for example:
  o Drug possession
  o Blood alcohol levels after an accident
  o Child protection issues/notification
  o Family violence
• Possession of or access to weapons

**Organic causes:**

*ORGANIC CAUSES OF CHALLENGING BEHAVIOURS SHOULD ALWAYS BE CONSIDERED WHEN EVALUATING THE PATIENT EXHIBITING AGGRESSIVE OR VIOLENT BEHAVIOUR.*

This is important even in the patient with a mental health diagnosis – never assume as medical conditions can mimic a mental health presentation.

Potential organic causes include but are not limited to:
- Hypoxia - Hypoglycaemia
- Trauma - Sepsis
- Metabolic disorders - Medications – withdrawal or toxicity
- Delirium - CNS disturbance: seizure disorders, stroke, infection, tumours

Organic illness should be suspected if the patient:
• Over 40 and or disorientated
• Altered conscious state
• Delusional
• Abnormal vital signs
• Sudden onset
• No previous psychiatric history

Any new onset of psychosis usually requires pathology testing and a CT Brain. Presence of alcohol and drug intoxication does not preclude early assessment however; more formal or thorough assessment may be required when free of the effects of these substances.

**Environmental/organisational issues:**

• Overcrowding
• Noise levels (can be a source of irritation and stress)
• Lack of privacy
• Inadequate staffing or times of increased activity e.g. mealtimes
• Inexperienced or inadequately trained staff
• Working alone or in an isolated situation
• Inadequate communication of clinical information to client
• Inadequate handover
- Inadequate emergency responses
- Inadequate security
- Inadequate entry/exit points
- Entry and exit points not within sight of staff
- Poor lighting
- Presence of objects that could be used as weapons

These examples are not exhaustive. Any situation where there is direct interaction with members of the public may expose staff to a threat of occupational violence and/or aggression.

**Question 1.**
List five potential causes of violence or aggression:

1. 
2. 
3. 
4. 
5.
PATIENT ASSESSMENT

All patients regardless of suspected diagnosis (e.g. psychiatric disorder) should have a full physical assessment on admission to the ED or at the specified timeframes for the ward area (at LEAST on commencement of your shift). Assessment should include vital signs, a head to toe assessment, mental state examination and a thorough history. This will provide you with a baseline assessment and assist you to determine if at any stage the patient is improving or deteriorating.

Assessment may also include (e.g. on admission to the ED or as required in the ward setting):

- Pathology
- Urinalysis
- Alcohol level
- Neurological observations
- Blood sugar level
- ECG

If unsafe to perform a physical assessment, there are things you can observe without direct contact with the patient. These include:

- Pupil size
- Colour of the skin
- Presence of sweating
- Trauma
- Demeanour
- Drugs/alcohol
- Slurred speech
- Voice/tone
- General appearance

A thorough mental status examination should also be performed. Key elements of a mental status examination include assessment of:

**Appearance:** age, dress, posture, facial expressions, eye contact, pupil dilation, general state of health and nutrition. Poor personal hygiene or grooming may reflect a loss of interest in self-care. Note: it is important to document in detail what the patient is wearing if you are caring for a patient who is involuntary (or likely to be made involuntary). The police will require a detailed description when they are contacted to locate the patient in the event that they abscond.

**Mood and Affect:** ask the patient “how do you feel”, observe their emotional tone. Are they flat, blunted, restricted? Ask them to rate their mood out of 10 (10 being the happiest they have been and one being the saddest). Affect refers to a person’s outwardly observable emotional reaction. It may include either a lack of emotional response to an event or an overreaction.

**Speech:** rate, volume, amount and characteristics.

**Thought content:** assess what the patient is saying for indications of hallucinations, delusions, obsessions, symptoms of dissociation or thought of suicide. Assess for delusions and grandiosity. Thought process – refers to the logical connections between thoughts and their relevance to the main thread of conversation. Irrelevant detail, repeated words and phrases, interrupted thinking (thought blocking, often sign of auditory hallucinations as they...
pause to ‘listen’ to the voice/s). Loose, illogical connections between thoughts may be signs of a thought disorder.

**Perceptions:** hallucinations, auditory, sensory and/or visual.

**Sensorium:** orientation, alertness, memory, judgment and insight. Ask the patient “why do you think you are here”?

**Risk:** to self or others. Are they suicidal? Do they have a plan? Are they expressing thoughts of harming others? How?

Don’t be too concerned with using psychiatric jargon unless you fully understand the meaning. It is more important to thoroughly document what you see and hear in your own words. If you are unable to perform certain components of the assessment e.g. safety issues, always clearly document.

The presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated.

**RISK MANAGEMENT**

Potential sources of weapons that may be used in violent or aggressive situations can be identified early and preventative activities implemented.

Things you can do to modify your immediate working environment to reduce risk and diminish ‘triggers’ include:

- Removing any potential weapons from the room/cubicle if caring for a patient at risk of violent or aggressive behaviour (i.e. free standing/unsecured IV poles, sharps, hard, blunt objects, IV trolleys and any unnecessary equipment)
- Be aware of any physical objects on yourself that may be used against you e.g. if wearing a lanyard around your neck, ensure that there is a safety breakaway mechanism (the type that releases when pressure is applied), remove scissors from pocket
- Be aware of what patient is wearing e.g. steel capped boots, belt with large buckle - all are potential weapons
- Avoid placing yourself at risk of being cornered
- Removing obstacles that could be in the way of the door and therefore access to a quick exit, always keep an open path
- Limit the number of people/visitors if appropriate (to decrease external stimuli)
- Wear low heeled, non-slip shoes
- Be vigilant throughout the encounter with someone who has the potential to be violent or aggressive
• Be aware of where the patient is and do not turn your back on them
• Take verbal threats seriously
• Call for help and initiate emergency procedures if unable to defuse the situation
• Be aware of your own skill set and confidence. If in doubt, ask for assistance.

Question 2.
List five environmental factors that you should take note of on commencement of your shift:
1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________

Question 3.
List five ways you can modify your immediate environment to decrease risk:
1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________

STRATEGIES TO LIMIT THE POTENTIAL FOR VIOLENCE

Being Aware of and Avoiding ‘Triggers’

A trigger is something that sets off an action, process, or series of events such as fear, panic, agitation. Triggers are personal and will be specific to individual patients but may include:

- Yelling
- Loud noises
- Lack of privacy
- Being teased or picked on
- Being isolated
- Security or police presence
- Not being listened to
- People too close
- Feeling lonely
- Feeling pressured
- Being touched
- Being stared at
- Darkness
- Arguments
- Not having control
- Contact with family
- Gender of staff (e.g. patient with Hx of sexual assault)

There may also be associational triggers for patients with a history of trauma, cultural issues. These are often things that staff may be unaware of however if they do arise, careful documentation for future potential situations is advised.
## Awareness of Behavioural Predictors of Impending Aggression/Early Warning Signs

Anticipation of evolving/impending aggressive behaviour and its prevention include recognition of the signs. Warning signs can include:

- Aggressive/hostile postures
- Aggressive/hostile attitudes
- Muscle tension
- Clenched teeth
- Wringing hands
- Bouncing legs
- Shaking
- Crying
- Giggling
- Singing inappropriately
- Pacing
- Breathing hard
- Shortness of breath
- Clenching fists
- Speaking in a loud voice
- Rocking
- Fidgeting
- Inability to sit still
- Swearing
- Restlessness
- Outbursts of emotion
- Agitation
- Sweating
- Alterations in tone of voice

Never ignore or dismiss a threat if the patient states that violence is probable. Acknowledge your instincts, gut feelings, sixth sense or intuition.

## Communication

Verbal communications should be:

- Calm, soft, neutral but confident
- Non judgemental
- Not angry
- Non authoritarian
- Respectful
- Empathetic, not sympathetic – don’t be judgemental of others feelings

It is vital that the staff member communicates in a non-authoritarian, non-controlling and respectful manner. When experiencing such responses, patients are even more likely to respond in an angry manner.

Non verbal communication:

- Ensure there is space between yourself and the patient, accommodate their personal space. Intruding into someone’s personal space tends to arouse and escalate a person’s behaviour
- Maintain an ‘open’ posture – open palms (not clenched), open arms (not crossed), feet apart
- Maintain a confident, non anxious approach
- Avoid interruptions to the interaction you are having with the person
- Avoid directly focusing on a particular part of the body, avoid prolonged eye contact as it may send a challenging message
- Avoid standing over the person
- Avoid an audience where possible (difficult if situation has escalated and team response has been initiated)
- Avoid extreme light, noise, activity - reduce stimulation where able
**Calming/Distraction Strategies**

Strategies for early intervention in an attempt to calm, distract, manage and minimise stress are also individual specific. Strategies may include things such as:

- Time away from the stressful situation
- Going for a walk (if appropriate)
- Talking to someone
- Lying down
- Listening to peaceful music
- Deep breathing
- Being left alone
- Reading a book
- Hugging a teddy bear/stuffed animal
- Eating
- Writing feelings down
- Drawing
- Ripping paper
- Calling friends or family
- Prayer, meditation, religious reflection

Such strategies may not be readily available, or appropriate (e.g. quiet time to listen to peaceful music in a busy Emergency Department). However, where able strategies should be implemented to assist the person to calm themselves and bring some control to the situation. If the patient has a past history of mental illness, effective strategies may be documented in their medical record in addition to other resources, details of past mental health admissions and risk assessments in the progress notes.

**Question 4.**

*List five potential ‘triggers’ for violent or aggressive behaviour:*

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

**Question 5.**

*List five warning signs of impending aggressive or violent behaviour:*

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

**Question 6.**

*Circle the correct response*

Verbal communication should be:

a. Calm, soft, neutral, respectful but confident
b. Loud, authoritarian and controlling
c. Both a and b are correct
**Defusion/De-escalation Strategies**

Certain strategies may reduce hostility and the possibility of violence. The initial focus should be on minimising the problem: attempting to identify the problem and addressing it.

**DO:**
- Listen to the patient and avoid early interpretations
- Use the person’s name to personalise the interaction
- Present a calm and caring attitude
- Be real, genuine
- Be interested, pay attention
- Be compassionate and helpful
- Establish and build a rapport – the effort you put in on initial contact can often help prevent a situation escalating
- Use empathy, not sympathy – acknowledge the person’s feelings/emotions as legitimate responses
- Be aware of and avoid potential triggers
- Always personally introduce change of staff to the patient e.g. when going on a meal break or change of shift
- If the person is a smoker, find out whether they are allowed cigarette privileges. Do not offer this without determining whether this is appropriate! If they are not able to have cigarette privileges, consider alternatives such as nicotine patches (check facility policy for whether medication order is required)
- Ensure frequent visual observations, ‘checking in’ with the person to see if they need anything
- Ensure prn medications are ordered if appropriate and available if they become required
- Ensure that ‘psychiatric specials’ who may be with the patient if they are under constant observation are aware of their responsibilities. Encourage them to interact with the patient where appropriate and report any signs of increasing agitation
- Ensure support is available

**DON’T:**
- Don’t interrupt the person if they are speaking
- Don’t patronise/talk down to the person
- Don’t ignore the person or what they are saying
- Don’t use humour
- Don’t provide misinformation, however, be conscious of the information you do provide
- Do not make promises that you are unable to keep/rewards that you are unable to provide
- Don’t give advice outside your scope of expertise
• Don’t react to abuse – listen, divert attention/distract. Ignore challenging questions that may challenge your position: redirect the focus to current issues
• Don’t match threats or give orders this is likely to escalate the situation
• Don’t isolate yourself or put yourself at risk
• Don’t be afraid to initiate a Code grey response if you are unable to defuse the situation

Tips for dealing with an agitated/aggressive person:
• One person speaking at a time
• Develop a plan together to dealing with the situation that you have agreed upon and identify individual responsibilities
• Implement the agreed upon plan and provide feedback on progress
• Set and enforce reasonable limits or boundaries with respect to aggressive or counter-productive behaviour
• Be firm and clear but allow the patient as much control over choices as possible
• Make instructions simple and unambiguous
• Clarify the messages. Listen, use re-statement to confirm, ask reflective questions
• If patient’s requests or demands are not possible always provide an explanation
• Offer alternatives for behaviour, treatment or stress release that may allow them to regain a sense of control
• Demonstrate control over the situation without using an authoritarian approach
• Use an even tone of voice even if the person’s communication style becomes hostile or aggressive

**Question 7.**

List five things to **avoid** when dealing with an aggressive or violent patient:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
RESPONDING TO AGGRESSIVE & VIOLENT BEHAVIOR

In the situation of impending physical attack, the safest option is to remove yourself from the situation. Failing this, self-defence and defence of others is permitted within reason. Self defence techniques, including evasive self-defence provide a controlled physical intervention when all other non-physical strategies have failed. This should be a last resort, and employees are directed to make themselves familiar with specific health care facility policy regarding self defence. In general, staff behaviour should be defensive rather than aggressive, controlling rather than punitive and use the minimum force necessary for the given situation.

In regards to the use of force, The Crimes Act (1958, s.462A) states that “a person may use such force not disproportionate to the objective as he believes on reasonable grounds to be necessary to prevent the commission, continuance or completion of an indictable offence or to effect or assist in effecting the lawful arrest of a person committing or suspected of committing any offence”. The defences to assault are:

- **C** Consent
- **A** Amicable contest
- **M** Misadventure or accident
- **E** Execution of law
- **L** Lawful correction or chastisement
- **S** Self defence

(Crimes Act, 1958)

The duty of care to patients also extends to controlling aggressive/violent visiting friends or relatives. Staff have the right to ask them to leave and initiate Code grey procedures if it appears they may cause danger to themselves, patients, employees or other people. Please refer to specific facility policy for specific information on this.

In the event of a violent and or aggressive situation, staff should employ strategies to diffuse the situation where appropriate. Non-threatening words and actions should be used, and the safety of the staff member and surrounding people maintained. If a situation is escalating or an incident occurs, immediate responses should be implemented. These may include:

- Review by a doctor
- Calm verbal and non-verbal communication
- Verbal de-escalation and distraction techniques
- Request that the aggressor leave (i.e. if the aggressor is a visitor)
- Calling more senior staff support and/or security/code grey team for assistance
- Withdrawal to a safer location
- Evasive self-defence
Code Grey and Code Black Events

Most health care facilities have a system for responding to violent or threatening situations/events. The local staff response should comprise the initial response to aggressive situations, however if assessment of the situation indicated further support is required to safely manage the situation, a Code grey (or Code Black) should be called.

Code Grey:
- Incidents of verbal aggression, threatened &/or actual physical aggression and violence involving patients, visitors, relatives, or staff
- Unarmed aggression and violence
- Incidents of threatened/actual self-harm and threatened suicide
- Physical aggression aimed at damaging property

Code Black:
- Serious events of violence or presence of a weapon. When a code black is called, immediate police support is required.

A Code grey can be initiated by anyone but is usually done by the nurse in charge. Switchboard should be contacted using the relevant facility emergency number and “Code grey”, ward area and specific location (i.e. bed 20) should be relayed to the operator. Staff should ensure their own safety and the safety of others at all times.

(Marroncelli, 2011).

The Code Team

The Code grey/black team usually comprises members of clinical staff (nursing and medical), security, OH&S and management. Usually present are:
- Emergency Coordinator
- Security staff x 2
- Mental health clinician/psychiatric nurse
- Medical Registrar
- Team Leader (nurse in charge or delegate from affected area)
- Orderly/Ward Support Personnel x 3

What does the code team do?
- Receive briefing from team leader
- Carries out brief risk assessment and formulate a plan
- Assigned roles by the team leader
- Takes part in restraint if necessary (as allocated)
- Attends post-incident debrief and provide feedback
Question 8.

If you were asked to call a Code Grey, what specific information would you need to relay to the operator?

METHODS OF MANAGING AGGRESSIVE AND VIOLENT BEHAVIOUR

Every effort should be made to prevent violence occurring however in the event that preventative measures, defusion and de-escalation strategies fail and a violent incident does eventuate, it is important that staff are aware of the response options.

Restraint, sedation and seclusion should not be the primary approach for managing aggressive or violent patients. Such methods should only be employed in emergency situations of aggression or violence where necessary for the protection of staff, others and the patient from immediate risk of injury, when less restrictive options have been unsuccessful and no other options of resolving the situation are available. The safety of all those involved should be the primary focus of any physical intervention. Any form of restraint (physical or chemical) or seclusion should be used as a last resort and if required should be implemented in accordance with the provision of The Mental Health Act 1986.

Note: behaviour that precipitates a decision to restrain or sedate a patient should first trigger investigation into the cause of the behaviour. (Consider organic causes as discussed earlier).

MECHANICAL RESTRAINT

Mechanical restraint refers to the application of devices such as belts, harnesses, manacles, sheets and straps on the person’s body to restrict their movement. It should only be used where an immediate risk of injury exists, and there is no other option available. If mechanical restraint must be used, the minimum required, least restrictive option should be used. ‘Reasonable force’ is the force required to prevent or stop the violent or aggressive person from causing harm to themselves or others and no more. In situations other than emergency situations, the use of restraint should only be undertaken following consultation with the relevant medical practitioner.

Specific written security procedures and policy should be consulted prior to restraining or assisting in the restraint of a violent or aggressive person. Any restraint intervention should be managed as a clinical intervention. Specific facility policy may vary however, all patients in physical restraints require regular behavioural and physical assessment, restraint release (where appropriate) and documentation is paramount.
There are different documentation and legal requirements between people restrained under the Mental Health Act and those who are restrained on medical grounds. Restraint of a non-mental health patient requires consent of a medical doctor. Specific policies and procedures will vary. Generally, as a minimum a Physical Restraint Assessment Order and Observation Chart must be completed.

Furthermore, the mental health act varies from state to state within Australia. Please make yourself aware of the specific policies of the place/s where you most commonly work.

**Restraint of Mental Health Patients**

In mental health services, mechanical restraint is regulated by the Mental Health Act and guidelines issued by the Chief Psychiatrist. It is considered a last resort intervention. The use of restraint in patients receiving treatment for a mental disorder in an approved mental health service can only be applied in specific circumstances:

(a) if that restraint is necessary—

(i) for the purpose of the medical treatment of the person; or

(ii) to prevent the person from causing injury to himself or herself or any other person; or

(iii) to prevent the person from persistently destroying property; and

(b) if the use and form of restraint has been—

(i) approved by the authorized psychiatrist;

or

(ii) in the case of an emergency, authorized by the senior registered nurse on duty and notified to a registered medical practitioner without delay (as soon as possible);

and

(c) for the period of time specified in the approval or authorization under paragraph (b).


If mechanical restraint is applied to a person, he or she must—

(a) be under continuous observation by a registered nurse or registered medical practitioner; and

(b) be reviewed as clinically appropriate to his or her condition at intervals of not more than 15 minutes by a registered nurse division 1; and

(c) be examined at intervals of not more than 4 hours by a registered medical practitioner; and

(d) be supplied with bedding and clothing which is appropriate in the circumstances; and

(e) be provided with food and drink at the appropriate times; and

(f) be provided with adequate toilet arrangements.


**NOTE:** Form MHA 28 Authority Mechanical Restraint must be completed and all relevant persons notified by the nurse in charge.
Application of Mechanical Restraint

If restraint is required, restraints should be applied efficiently in an organised, coordinated approach. The Code Grey team will apply the restraints in an emergency situation. Care should be taken to avoid injury to the patient, and the patient should be informed of what is happening and reassurance provided.

Restraints should be available and checked to be in working order prior to their application. Padded cuff restraints should be used if restraining limbs for patient comfort and to help prevent areas of skin breakdown/pressure areas.

If restraint is required, the patient should always be informed of what is happening and why, and be assured that they are safe. The process should be as follows:

- Call a Code Grey (never attempt to restrain a person without calling a Code grey)
- Remove all other patients/visitors/unnecessary staff from the area
- There should always be someone in charge of the Code Grey who is giving clear instruction. This is usually the nurse in charge or the attending psychiatric nurse
- Ensure any medications that are anticipated to be required are ready for administration PRIOR to commencing the restraint
- Maintain calm, consistent approach to the patient
- Staff are allocated as follows:
  - one person for each of the patient’s arms
  - one person for each of the patient’s legs
  - one person ensuring the patients head is safe and to provide information and reassurance.
  - **Note**: the person at the head may be the only person talking to the patient. It is their role to provide reassurance to the patient throughout the restraint process
  - one person to administer medication if required
  - extra people may be required to apply the restraints while team members have control of the patient’s limbs
- Restrain patient when decided by the team leader
- Administer medication if ordered/necessary
- Review interventions with Code grey team
- Process events with witnesses and other staff as appropriate or required

Risks and adverse events associated with use of restraints include (but are not limited to):

- Pressure areas
- Agitation
- Frustration
- Falls
- Strangulation/positional asphyxia
- Compromised airway due to aspiration or choking
• Stiffness
• Loss of dignity
• Incontinence
• Loss of muscle tone and strength
• Decreased mobility
• Reduced bone mass
• Neck or chest compression
• Bruising
• Circulatory problems
• Dehydration
• Injury from mechanical restraint
• Increase in psychological distress
• In rare circumstances, death

**Nursing Care of the Restrained Patient**

**General Guidelines**

Following application of mechanical restraints:

• Ensure that the patient is safe, airway is clear and the patient is as comfortable as possible
• If previously removed for safety, replace oxygen and suction in cubicle/room
• Monitor airway, breathing, circulation and regular physical observations – patients are often sedated and therefore have an at risk airway
• Reassure and explain all interventions, prior to undertaking tasks
• Be familiar with restraints and how to remove in case of an emergency
• Commence restraint paper work as per Mental Health Act for an involuntary patient or as per the facilities protocol if the patient is not restrained under the Mental Health Act
• Complete nursing documentation and Code grey paper work with as much detail as possible. Rationale for clinical decision making needs to be clearly documented in the patient’s clinical file
• Commence fluid balance chart (and IV therapy chart if IV therapy in progress)
• Take responsibility for your patient; do not rely on psychiatric specials to undertake nursing tasks. Even if a psychiatric special is present, the patient is still your responsibility
• Continue to observe and assess the patient
• The devices should be removed (one at a time) with caution, and the limb and exercised and skin checked (refer to restraint paperwork for frequency)
• Patient needs including hydration, elimination, comfort and social interaction must be regularly assessed and attended to
• All needs and patient interaction should be attended to with caution, and the safety of both staff and the patient the primary concern
- Be aware that patients may spit - wear protective eye wear at all times during encounter
- Debriefing as required may follow the incident

Note: clear, written policies regarding the use of restraint and/or sedation will be available in each health care facility. These must be followed.

Guidelines for Patients Restrained Under the Mental Health Act

In addition to the general nursing responsibilities, the following are required when caring for a patient restrained under the Mental Health Act 1986.

Following application of mechanical restraints:
- The patient must be under continuous observation at all times by a registered nurse or medical practitioner with the focus being on ensuring the person’s safety
- The patient must be reviewed at least every 15 minutes by a Registered Nurse (Division one) and documented on the MH28A Mechanical Restraint Clinical observations form
- Each review must include:
  - physical observation – pulse, respiration, blood pressure, skin colour, skin condition at restraint/s site, posture, level of consciousness and comfort level
  - mental status observation – including pattern and content of speech, attention, level of motor activity
- An examination of the patient by a medical practitioner must occur at intervals no longer than four hourly. The examination must cover the person’s mental and physical status, be as thorough as the circumstances permit and include an assessment of the need for continued restraint according to the criteria set out in the Mental Health Act 1986
  (Tanaghow: Chief Psychiatrist, 2006)

Restraint in Aged Care

The use of restraint in aged care is a sensitive issue. The needs of residents with challenging behaviours should be managed effectively with a specific plan of care that ensures dignity and respect. According to The Standards and Guidelines for Residential Aged Care, management of resident behavioural should be in accordance with best practice guidelines, and use of restraint is not advocated except for the protection of the resident or others from injury. Restraint if used is as a last resort. Each health care service will have a specific set of policies and guidelines regarding management of challenging behaviours including aggression and the use of restraint. Please refer to these for further information.
  (Department of Health and Ageing, 2004).
**Terminating the Restraint Intervention**

Patients should have restraints removed as soon as they meet the criteria for release. If appropriate and safe, the behaviour that precipitated the use of restraint should be reviewed with the patient and restraints removed.

**Question 9.**
List five risk factors/adverse events that are associated with mechanical restraint:

1. _____________________________________________
2. _____________________________________________
3. _____________________________________________
4. _____________________________________________
5. _____________________________________________

**Question 10.**
Please circle the correct response

A patient who is restrained under the Mental Health Act must be reviewed:

a. At least every 15 minutes  
b. At least every 30 minutes  
c. At least every hour  
d. At least every four hours  

**Question 11.**
This review of the patient who is restrained under the Mental Health Act must be performed by:

a. Either a Registered Nurse Division one or two  
b. A Registered Nurse Division one  
c. A psychiatric special  
d. Any of the above

**CHEMICAL RESTRAINT**

Chemical or pharmacological restraint is the treatment with medications to control violent or aggressive behaviours. It is primarily used in an acute situation to prevent harm to the patient or to prevent the patient from harming others. The goal is to alleviate anxiety, tension, and motor excitement, not sedation. It is not intended to treat psychiatric symptoms (this takes two to three weeks). Clinical response ranges from controlled and acceptable behaviour to drowsiness (rousable). No sedation protocol is 100% safe. Medications should be given with caution and vigilant monitoring.

Commonly used medications include:

- Antipsychotics: Olanzapine (either oral or IM)
• Benzodiazepines: Valium, Midazolam (only if the patient is highly agitated. Note: full airway monitoring required) - sedative effects, rapid action

Factors which will influence the selection of drug will include:
• Speed of onset
• Availability of an IM injection
• Access
• Previous history of response
• Patient’s level of agitation e.g. oral if minimal arousal, IM if highly aroused, IV only used in Midazolam administration

Common adverse reactions:
• Airway obstruction
• Respiratory depression including apnoea
• Aspiration
• Hypotension
• Laryngospasm (particularly in the context of antipsychotic medication administration) (Pinder, 2011).

Sedation protocols

Sedation protocols may be used as a guide for the administering of prn medications to a person exhibiting signs of aggressive behaviour. There are wide range of medications that can be used and the medical team will select this according to individual factors such as allergies, past history and current medications. These protocols are generally based on the degree of agitation exhibited. The type of medication and route will depend on the degree of agitation/aggression and the patient’s ability to comply with instructions.

*The aim of sedation is for the patient to exhibit decreased level of agitation.

The following is an example of an Emergency Department sedation protocol. Note: protocols will vary between departments and facilities, the following is given as example only, specific facility written policy should be followed. Each level describes potential behaviours and the appropriate medication and route that should be used to manage the behaviour. The clinical response to sedation falls along a continuum with controlled behaviour at one end and rousable drowsiness (NOT unconsciousness or non responsiveness) at the other (Pinder, 2011).

Level 1
Patient is observed as mildly aroused, pacing but still willing to interact reasonably with requests.
Nursing/ Medical Response:
• Pre-empt intervene early, address concerns and fears
- Offer Benzodiazepines e.g. Diazepam 5-10mgs, give in liquid form if possible, faster acting
- Monitor compliance
- If ineffective consider per oral level 2

**Level 2**
Patient observed to be moderately aroused, agitated, verbally aggressive, becoming more vocal, with a reduced capacity to control behaviour and emotions.

**Nursing Medical Response:**
- Notify person in charge, treating doctor
- Administer antipsychotic such as Olanzapine 10mg wafer form
- Can be combined with benzodiazepines
- If ineffective consider parenteral interventions

**Level 3**
Aggressive behaviour is obvious and poses an imminent threat to the safety of all.
Patient is highly roused, distressed and fearful. Violent toward self, others or property OR patient refuses all medication and continues to be potentially aggressive or violent.

**Nursing/Medical Response:**
- Code Grey Called
- Monitor surroundings
- IMI Olanzapine 10mg or Midazolam 0.09mg/kg
- EPSE’s should be monitored and treated with Benzotropine 2mg IM or IV if symptoms severe
- Patient may require restraint during this period

If the patient requires transfer to the mental health unit, be aware that some units will not accept patients until certain criteria or specified timeframes are met. For example, the patient can be drowsy however must be responsive to verbal stimuli and able to effectively maintain their own airway (Pinder, 2011).

**SECLUSION**

According the Mental Health Act (1986) seclusion is defined as "the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside".

Seclusion involves removing a person from contact with staff, other people and stimuli such as noise and activity. Degree of seclusion varies from confining a person in a room with a closed door (locked or unlocked) to placing the person in a specific seclusion room containing a mattress on the floor only.
Seclusion is a last resort intervention that is only used in very specific circumstances. Discussion of the specifics of seclusion is not within the scope of this package. Please refer to specific facility policy regarding seclusion for more information.

**DOCUMENTATION**

Every workplace must keep records of each incident that involves any act of aggression or the use of any kind of restraint. An Incident Report should be generated for every act of aggression. Documentation in a patient’s medical record must be in accordance with policy and privacy considerations.

**Incident Reporting**

Incident report forms should record factual information and be clear and concise:

- Who was involved
- When the incident occurred
- Location of the incident
- Whether a weapon was used
- A description of how the incident occurred
- A description of the outcome
- What injuries were sustained (if any)

Victoria now uses the Victorian Health Incident Management System (VHIIMS) which is a direct electronic report to the Health Department.

**Alert Systems**

Alert system such as those used to identify patients with life threatening allergies can be used to identify patients with behaviours that pose a risk to health and safety. The alert should cover the following issues:

- Purpose of the alert
- Person to whom the alert refers (i.e. the patient, a problem family member who may be regularly visiting)
- Plan for behaviour management

**Note:** Refer to specific facility policy as methods of managing alerts will vary.
Code Grey/Code Black Documentation

Information that should be collected in respect to code responses should include:

- Response type (Code grey or Code black)
- Date
- Time called
- Time called down
- Location
- Age of aggressor
- Gender of aggressor
- Type of aggressor (patient, visitor etc)
- Number and position (i.e. Dr, ANUM, OH&S) of response team members
- A description of the behaviour that resulted in the activation of the code
- Any other factors which contributed to the behaviour/incident

Note: rationale for clinical decision making (for example application of restraints or administration of sedation) must be clearly documented in the patient’s clinical file.

Restraint Documentation – Mental Health

Important things to document in the use of restraints include:

- The form of mechanical restraint used
- The reasons why that restraint was used
- The name and signature of the person who approved or authorized the use of the restraint
- The name and signature of the person/people who applied the restraint
- The time the restraint was initially applied
- The period of time for which the person was kept restrained
- If the authorised psychiatrist varied the interval at which the person was medically examined, the reason for that variation

Question 12.
List five things that should be documented in an incident report when reporting an incident of violence or aggression:

1. _____________________________________________________________
2. _____________________________________________________________
3. _____________________________________________________________
4. _____________________________________________________________
5. _____________________________________________________________
POST INCIDENT RESPONSE

For the Patient:

Once the episode of acute agitation/aggression is managed, long term strategies are required. Once it is safe and the patient meets the criteria, a careful physical and psychological assessment should be performed. If a patient has received sedation, there is usually a four hour policy where they cannot be formally assessed or transferred. If a person is under the influence of alcohol, this does not preclude early assessment if safe to do so, however they may required further assessment when they are no longer under the influence. These criteria may be facility specific (please refer to facility policy).

Depending on the underlying issues and cause of the behaviour, transfer to an appropriate Psychiatric facility may be required. Often, when the primary problem is successfully treated, the associated aggressive behaviour is reduced. Commencement of new or modification of existing medications may be required.

For Staff:

Exposure to workplace violence and aggression may cause physical, behavioural, cognitive and emotional reactions. These can occur as a direct result or indirectly as a witness to an incident of violence and aggression and can be acute or cumulative. The impact of all types of violence on staff should not be underestimated.

Emotional responses may include, but are not limited to:
- Fear - Shock - Anger - Worry
- Disbelief - Anxiety - Frustration - Distress
- Confusion - Helplessness - Sadness - Exhaustion
- Headaches - Depression - Embarrassment - Guilt
- Loss of control - Loss of self-esteem - Insecurity - Powerlessness
- Loss of confidence - Inability to sleep - Increased irritability

Responses will vary depending on the severity of the incident, but may include:
- First aid and medical treatment if required
- The staff member/s who was the target of the behaviour should be given the option of being relieved of their duties
- The staff member/s that was the target of the behaviour should be given the opportunity to talk through/debrief immediate issues with a counsellor and/or other employees
- The staff member who was the target of the behaviour and witnesses should be offered further debriefing or ongoing counselling
- The incident should be formally reported as per facility policy
- The incident should be reported to Belmore Nurses Bureau within 30 days of you becoming aware of the injury/illness
De-briefing

Debriefing is usually made available to staff involved following an incident of workplace violence or aggression at the health care facility. Debriefing may include:

- The sharing of personal experiences (to diffuse the impact of violence)
- Discussing what has happened, helping those who have been affected to understand and come to terms with the incident
- Focusing on the facts of the situation
- Provision of reassurance and support
- Provision of helpful information and explanation of further assistance that is available

Counselling

Counselling services can be arranged for Belmore Nurses Bureau employees who may require it following incidents of workplace aggression or violence. Please contact Belmore if counselling is required.

External Services for Nurses

For anyone experiencing health issues related to mental health or substance use, The Nursing and Midwifery Health Program Victoria (formerly the Victorian Nurses Health Program) is an independent support service for nurses, midwives and students of nursing and midwifery. They provide ‘sensitive and compassionate screening, assessment, referrals, individual support sessions and groups for those seeking help to manage these health concerns’.

Callers seeking urgent attention out of office hours with Substance Use issues can phone Direct Line 1800 888 236
Website: http://www.nmhp.org.au/NMHP/Welcome.html

Question 13.
List five potential emotional responses that may occur after witnessing or experiencing an incident of violence or aggression:

1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________
5. __________________________________________________________
SUMMARY

This learning package has provided information for Belmore Nurses Bureau employees on how to manage aggressive behaviour in the health care setting. Patients exhibiting aggressive or violent behaviour must be first assessed for the possibility of co-morbid conditions and reasons behind the behaviour. Prevention through early identification of risk factors and triggers is essential and strategies for defusing and deescalating a potentially aggressive or violent situation should be implemented. Failing this, any physical means used to control the situation such as restraint or sedation should be the minimum required to achieve safety for the patient and staff members. Any intervention should be implemented with the focus on safety and respecting the rights and dignity of the individual.

Thorough documentation, incident reporting and alert systems will facilitate review of incidents and provide alerts for future care in people with a history of violence or aggression. Exposure to violence and aggression can have acute and long term effects on individuals. Debriefing should be attended, and follow up counselling sought if required.

RESOURCES FOR FURTHER LEARNING

- Journal Articles
- Textbooks
- ANF Zero Tolerance (Occupational violence and aggression) Resource Package
  Website: www.anfvic.asn.au
- Frequently asked questions about the Mental Health Act
- Worksafe Victoria - Emergency Response
  Phone 13 23 60 to report serious workplace emergencies, 24 hours a day.
  Information: (03) 9641 1444 Toll-free: 1800 136 089
  Email: info@workcover.vic.gov.au
  Website www.worksafe.vic.gov.au
- The chief psychiatrist website (information and specialist advice on various aspects of clinical service and clinical issues in relation to the Mental Health Act)
REFERENCES


Package prepared by Rachel Wolfe with assistance of Anne-Maree Pinder & Angela Marroncelli
## APPENDIX A

**Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria’s mental health services**

<table>
<thead>
<tr>
<th>What the legislation says</th>
<th>What this means for developing strategies to reduce workplace violence</th>
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<tbody>
<tr>
<td><strong>Occupational Health &amp; Safety Act 1985 Section 21 – duties of employers</strong></td>
<td><strong>Working environment</strong></td>
</tr>
<tr>
<td>(1) An employer shall provide and maintain so far as is practicable for employees a working environment that is safe and without risks to health.</td>
<td>Any aspect of the workplace itself, the work processes; including what is done and how it is done. This is clearly relevant when considering how to reduce occupational violence.</td>
</tr>
<tr>
<td>(2) Without in any way limiting the generality of sub-section (1), an employer contravenes that sub-section if the employer fails-</td>
<td>Plant</td>
</tr>
<tr>
<td>(a) to provide and maintain plant and systems of work that are so far as is practicable safe and without risks to health;</td>
<td>Includes any machinery, equipment, appliance and tool, any component thereof and anything fitted, connected or appurtenant thereto.</td>
</tr>
<tr>
<td>(b) to make arrangements for ensuring so far as is practicable safety and absence of risks to health in connection with the use, handling, storage and transport of plant and substances;</td>
<td>Systems of work</td>
</tr>
<tr>
<td>(c) to maintain so far as is practicable any workplace under the control and management of the employer in a condition that is safe and without risks to health;</td>
<td>Substances</td>
</tr>
<tr>
<td>The Occupational Health and Safety Act 1985 defines ‘practicable’ as having regard to: (a) the severity of the hazard risk in question; (b) the state of knowledge about the hazard or risk and any ways of removing or mitigating the hazard or risk; (c) the availability and suitability of ways to remove or mitigate that hazard or risk; and (d) the cost of removing or mitigating that hazard or risk.</td>
<td>So far as is practicable</td>
</tr>
<tr>
<td>Taking steps to eliminate or minimise risks of occupational violence in the light of existing knowledge about occupational violence, its sources and ways of controlling it. Any consideration of cost and practicability should include consideration of the direct and indirect costs of injury and illness, including workers compensation costs and premiums, loss of skilled staff, and other costs associated with violence and aggression. ‘So far as is practicable’ will involve weighing up these factors.</td>
<td></td>
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</table>
(e) to provide adequate facilities for the welfare for employees at any workplace under the control and management of the employer (should be read in conjunction with the First Aid and Workplace Design codes); or

<table>
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<tr>
<th>Welfare</th>
<th>In the case of occupational violence, means providing first aid, counselling, incident debriefing and any follow-up action to minimise the severity of the effect of any incident on employees.</th>
</tr>
</thead>
<tbody>
<tr>
<td>f) to provide such information, instruction, training and supervision to employees as are necessary to enable the employees to perform their work in a manner that is safe and without risks to health.</td>
<td></td>
</tr>
<tr>
<td>Information, instruction, training and supervision</td>
<td>Provision of training and information about how to manage workplace violence and the existence of appropriate supervision to ensure staff are protected.</td>
</tr>
</tbody>
</table>

Section 25 – Duties of employees
(1) While at work, an employee must:
(a) take reasonable care for his or her own health and safety and for the health and safety of anyone else who may be affected by his or her acts or omissions at the workplace, and
(b) co-operate with his or her employer with respect to any action taken by the employer to comply with any requirement imposed by or under this Act.

(2) An employee shall not:
(a) wilfully or recklessly interfere with or misuse anything provided in the interests of health and safety or welfare in pursuance of any provision of this Act or the regulations; or
(b) wilfully place at risk the health and safety of any person at the workplace.

| Employees must: | - follow workplace practices and policy designed to reduce occupational violence and aggression risk
- report to management all incidents of occupational violence and aggression
- identify, report and document all risks of occupational violence and aggression to management and other staff through appropriate systems, such as during verbal handover, by notation and by alert flagging of clinical file and central database file.
- cooperate with management and OH&S representatives in the development and implementation of strategies to reduce occupational violence and aggression within the workplace
- actively monitor behaviour of consumers and be alert to signs of escalation to minimise and avoid such escalation
- increase skills and understanding by attending training provided by the employer
- take reasonable care while at work for their own health and safety and that of others and not knowingly place themselves or work colleagues and others at risks by their acts or omissions
- refuse to work in a knowingly unsafe situation. |

DHS (2004, p.7-8).
## Example of Alert Notification

**Client alert**

This page should be placed prominently in the front of the client’s file to inform staff of potential risks to their health and safety.

Based either on assessment or past behaviour, the following potential areas or risks to staff have been identified:

- [ ] Client (patient/resident)
- [ ] Carer
- [ ] Environment
- [ ] Other, as indicated

_________________________________________________________________

Staff are advised to check current notes to familiarise themselves with these risks before contact, and to always use safe work practices themselves and with respect to others.

Client’s file entries must inform others of any risks or potential risks.

Signed ___________________________ Designation ___________________________

Last updated _____ / _____ / _______

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Source: Zero Tolerance (Occupational Violence and Aggression) Policy and Toolkit, Australian Nursing Federation (Victorian Branch), 2002