

## DEALING WITH POTENTIALLY DANGEROUS PATIENTS



Health care providers regularly deal with patients under stress and are exposed to the risk or threat of violence in the workplace at higher rates than most other professions. Unfortunately, the nature of the profession makes it necessary for providers sometimes to care for, manage, or defend themselves from a person who is acting out violently. The following information is helpful for all health care personnel to be aware of and we encourage it to be shared with your staff.

### RISK FACTORS FOR VIOLENCE IN PATIENTS

*The strongest risk factor for violence is a history of violence.*

Other risk factors include:

- Intoxication
- Delirium and delusional states
- Suicidal intent
- Fear, anger, and revenge
- Explosive or antisocial personality traits
- Communication barriers, like language, sensory or intellectual impediments

*Some of these are knowable in advance of a confrontation, but many times they are not.*

Emergency medicine providers in particular, often face the challenge of conducting an assessment on a resistant patient. EMTALA rules that require a clinical evaluation do not make exceptions for difficult cases. However, the standards of reasonableness and reality apply in the ED and everywhere else. *No clinician is required to put their safety at risk to comply with the law.* The question is whether all available means have been used to protect

staff—and other patients—as well as the violent individual.

Emergency and some urgent care facilities that are subject to EMTALA are obliged to develop resources and policies for managing patients who create risks to themselves or those around them. Some form of this advice logically extends to all health care providers. It must be remembered that violent patients may themselves be vulnerable to injury or adverse health outcomes, and need interventions by behavioral health, social services, law enforcement, or the courts. The organization's legal advisor should be readily available for crisis management for situations such as applying for a restraining order or handling refusal of treatment by an incompetent patient.

### AWARENESS OF SIGNS IN PATIENT BEHAVIOR

Violence can be impulsive and unpredictable. But, there are signals that give a sense of when an assault may be impending. Many of these are intuitively apparent, including head shaking, jaw tightening, eyes diverted, and impingement on interpersonal space. Verbal signals like shouting and threatening are familiar. *The important goal is neither to disregard*

*these behaviors, nor to escalate them by overreacting.* It is hard to be non-judgmental in the face of an assault, but training and experience can help people remain composed and professional in situations that can be deflected or de-escalated.

OSHA requires employers to provide their workers with “a workplace free from recognized hazards.” Facilities should implement comprehensive plans addressing violence prevention, warning signal recognition, threat assessment, verbal and physical de-escalation, and other topics. These and other valuable tips are outlined in “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers,” which can be downloaded at <https://www.osha.gov/Publications/osh3148.pdf>

### CONSIDERATIONS FOR ADDRESSING TENSE SITUATIONS

A delicate judgment needs to be made sometimes between confronting a belligerent person with threats (e.g., “You’re making me very uncomfortable. If you continue to act like this, I’m going to call security.”) versus attempting to bond with them by being accommodating (e.g., “I

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definitely get why that's bothering you. Let me see if I can do something to help.") Unfortunately, there is no fixed rule for when to apply one tactic or the other. The practitioners who are most talented in this art tend to be those with experience. One important point about verbal confrontation is that high stress levels can generate a state of "auditory exclusion," in which any party might actually not be able to hear questions, instructions, or commands.

Besides offering training, facilities and practices need to assure adequate staffing for safety. They can support their staff with policies that encourage personnel to take unobtrusive, protective steps at an early stage of discomfort. Some of these include involving chaperones or asking a colleague to join a tense discussion, maintaining interpersonal space, not leaning/reaching across the patient's body, or not allowing a patient to block the way out of a room. In some cases, it might be better to avoid giving a patient the sense of being physically or emotionally "cornered."

Physical and technological measures are available that can be useful. Some of these are flags in the patient chart about a past history of violence or delirium, a coded flag on the patient's door or stretcher, color-coded patient gowns or wristbands, "panic buttons" in patient care areas or even wireless alarms carried as ID badges. Appropriate physical barriers (such as reception desks) and clear pathways within the facility are common sense measures. Visible video cameras may have a deterrent effect (and recordings can help defend providers, when their actions are proper.)

Finally, it should be remembered that people who have been subjected to violence may carry a bit of latent PTSD. The very training and policy discussions intended to improve safety can be experienced as stressful by some trainees. Some people don't have the temperament to intervene in a violent encounter, and it is not reasonable to build this duty into everyone's job requirement.