

Clinical Safety in Neurology

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Violent Incidents in the Neurology Setting

Violence directed toward clinicians appears to be increasing in frequency. Health care workers experience close to two fifths of the nonfatal assaults on employees in the United States. This increase may be attributed to patients in the care of clinicians becoming more violent or possibly to greater awareness of violence in clinical practice.

Clinicians typically deny that violence by patients is a problem. However, a crucial step in addressing the risk of clinician assault by patients is acknowledgment that a problem exists.

Recognition that violence by patients in the neurologic setting is a problem and determination of the extent of the problem are hindered by a dearth of data. Anecdotal reports document aggression by some neurologic patients. However, the incidence and prevalence of violence in neurologic settings are unknown.

To have appropriate plans to minimize violence in neurology, neurologic administrators must develop standard operating procedures for dealing with violent incidents. Aggressive incidents worthy of consideration include threatening gestures, loud voices, and threats as well as direct physical acts. Neurology workplaces must be safe for patients, clinicians, and staff.

Although the incidence and prevalence are unknown, the authors hypothesize that aggression by neurologic patients is unfortunately a likely occurrence. The clinical practice of neurology by referral to private practices likely eliminates frequent sources of violence. The current article focuses on risks likely encountered by neurologists consulting to emergency and psychiatric wards. The authors hypothesize that aggression toward clinicians in some neurologic settings is roughly comparable to that observed in emergency and psychiatric settings because some neurologic disorders are associated with violence. For example, individual psychiatric inpatients are estimated to perpetrate an average of as many as 7.9 violent incidents.^[1] As many as 40% of clinicians are estimated to be victims of nonfatal assaults.^[2]

Neurologists and other clinicians are at risk of assault by patients, particularly in emergency departments, psychiatric units, forensic units, and prisons. Therefore, the authors urge neurologists and other clinicians working with neurologic patients to be aware of the potential for assault by patients and to act accordingly.

Awareness of the extent of violence that may occur in selected neurologic settings can be fostered by review of studies of violence in psychiatric wards and hospitals. For example, recent data are available about the characteristics of violent inpatients on locked psychiatric wards of general hospitals.

In a study of the violent episodes involving patients admitted to a locked inpatient psychiatric unit in a general hospital in Italy over 5 years, Grassi and colleagues noted that violent episodes were more likely to occur during the daytime, within the first week of admission, and when the ward census exceeded the maximal allowed number of 15 patients. Violent episodes were more common in patients who lived with their nuclear family. The mean length of stay of violent patients was more than twice that of nonviolent patients. The corridor of the unit was the most common site of violent episodes. Most violent episodes were directed at staff members and other patients and less frequently at visitors.^[3]

In a study of violent episodes occurring in a district general hospital of the National Health Service in the United Kingdom, Soliman and Reza reported that most violent episodes occurred in sitting rooms and corridors at night and on weekends. They noted that the staffing is typically markedly reduced at night and on weekends. In this British sample, violent patients had a mean length of stay of 105 days, much longer than nonviolent patients. Soliman and Reza also observed that first violent episodes occurred on the 38th day of hospitalization on average. They noted that the violent patients in their study exhibited high levels of aggression and anxiety. These patients also experienced frequent changes in medication and as-needed doses of benzodiazepines and antipsychotic drugs. Violent patients were also more likely to have involuntary admissions.^[1]

Scott and Resnick classify aggressive behavior as affective or predatory. Aggressive violence results from a perceived threat in the external world or from internal stimuli. On the other hand, with predatory violence, the person seeks someone to harm.^[4] 'Predators are more dangerous. Predators often are without remorse.'^[4]

Violence may include physical violence and verbal violence. Therefore, workplace violence encountered by neurologists, particularly in emergency and psychiatric wards, may include hitting the wall, throwing an object, and glaring at the clinician.

- Examples of physical violence

- Biting
- Chasing
- Defecating
- Grabbing
- Hair pulling
- Hitting
- Kicking
- Pinching
- Poking
- Punching
- Pushing
- Scratching
- Slapping
- Spitting
- Stabbing
- Swinging
- Throwing

- Unwanted physical contact
- Urinating
- Examples of verbal violence
 - Abusive language
 - Bullying
 - Ethnic slurs
 - Intimidation
 - Ridicule
 - Swearing
 - Threatening gestures
 - Threats of injury
 - Threats of violence
 - Yelling

A patient's likelihood of becoming dangerous, of causing serious physical and psychological injury to others, must be assessed by neurologists consulting to emergency and psychiatry wards to prevent morbidity and mortality of caregivers. Not only must clinicians be aware of their personal risk, but they also must abort assaults on other staff, other patients, and the general public. The safety of every member of the treatment team must be protected.

Students, residents, and other trainees are among the staff most likely to be assaulted by patients. Their lack of experience may result in entry into a dangerous situation that experienced staff members avoid. For this reason, experienced personnel must warn inexperienced clinicians of likely potential dangers. Staff members must function as a cohesive team so that staff members who sense a likely assault on another warn the potential victim and summon help. Patients on the verge of committing assault may be helped to control their violent impulses when confronted by a large team of several staff members including security and police officers. Naive trainees must be warned to avoid potentially dangerous situations alone.

- Sites of possible clinician assault by neurology patients
 - Emergency department
 - Corridors on inpatient units
 - Outpatient settings
- Groups of clinicians at risk for violence by neurology patients
 - Caretakers
 - Emergency medical services (EMS) providers
 - Emergency medical technicians
 - Home health aides
 - Nurses
 - Nursing aides
 - Paramedics
 - Physicians
 - Protective services staff

- Social workers

Emergency medical technicians and paramedics are at high risk for assault by neurology patients. Emergency calls may be made for individuals who are experiencing dementia, mental retardation, head trauma, intoxication with alcohol or other substances, psychosis, and other conditions associated with possible violence. Because of similarities in uniform, emergency medical technicians and paramedics may be confused with police officers. Individuals who maintain negative social attitudes to the police may assault these workers by mistake.

Home health aides are vulnerable to assault by neurologic patients. The patient may misinterpret a home health aide entering the home to be an intruding and unwanted stranger. Because the home health aide is typically alone with the patient in the home, the aide is unprotected in case of violence. If patients have a history of violence, then clinicians must consider whether home care is appropriate. Violent patients may require a more restrictive environment such as a locked nursing home where staff members are available around the clock to handle violent episodes. The prescribing clinician must consider the safety of the health worker when prescribing home care by a home health aide or a visiting nurse. The health workers must be alerted to the potential for violence. A team of at least 2 health workers is wise for home care with a potentially violent patient.

Nurses appear to be likely victims of assault by patients. In 2001, Berg and colleagues reported that 80% of nurses are assaulted at least once in their careers.⁶ Nurses and their aides are particularly vulnerable to assault by patients because they have constant face-to-face contact with patients. Patients may be unhappy about being hospitalized. They may be confused, disoriented, or paranoid. They may misinterpret the goals of nursing care or believe that nursing personnel are going to hurt or kill them.

Administration of medication is a likely time for assault of nurses by patients. Evening and night shifts may also be risky times for possible patient assaults. This may be particularly dangerous when violent male patients confront reduced numbers of female nursing personnel. By acknowledging the likelihood of assault by potentially violent patients, clinicians may prevent aggression by transferring violent patients to locked psychiatric or prison units. Assigning a male nursing staff member full-time to a violent patient may help to abort aggression by the patient.

Nurses experience violence from other nurses, physicians, and nonnurse managers. They experience a lack of support from colleagues when physicians and managers do not do everything possible to prevent violence directed at nurses. Therefore, colleagues must make every effort to demonstrate to nursing staff that the safety and welfare of nursing and other staff members are paramount. When supervisors assign nurses to dangerous situations without regard to the likely violence, nurses frequently perceive their supervisors as callous. Nurses often think that others do not care.

Physicians are at risk for assault by patients, particularly in emergency and psychiatric wards. Psychotic patients may develop paranoid delusions about neurologists. Patients or their families may assault the neurologist when a patient experiences morbidity or death. Patients whose requests for disability, absence from work or school, or other benefits are denied by a neurologist may then attack the neurologist. Clinicians are wise to take every threat by a patient seriously. When patients who have previously threatened clinicians have subsequent office visits, clinicians may benefit from the presence of security officers and police in the examining area. Keep doors ajar for safety.

Members of protective services, including security and police, are at risk for assault. Answering calls by teams of at least 2 officers is wise to prevent confrontation of a single officer by a violent patient.

Social workers are also at risk for assault by neurologic patients, especially on emergency and psychiatric wards. The patient may be acting on paranoid delusions or delirious confusion. Patients who do not obtain immediate insurance, housing, food, or other benefits may respond with aggression to social workers.

To prevent the occurrence of violence to neurologic patients, particularly on emergency and psychiatric wards, clinicians should avoid situations that increase the risk of violence and triggers of violence and be especially cautious with patients whose medical or psychological status might predispose them to violence.

- Clinical situations that increase the risk of violence
 - Denial of disability status
 - Absence of escape paths
 - Cultural incongruities
 - Insufficient staff
 - Foreign language
 - Malfunctioning equipment
 - Portable furniture
 - Portable objects
 - Unobserved patients
 - Inadequately trained protective services staff
- Triggers of violent episodes
 - Denial of admission requested by a patient
 - Disrespect, real or apparent
 - Fear
 - Frequent medication change
 - Frustration
 - Gang participation
 - Involuntary hospitalization of an unwilling patient
 - Hunger
 - Job loss
 - Lack of privacy
 - Long wait
 - Noise
 - Police presence
 - Poor surveillance
 - Rude behavior of staff
 - Sedative drugs in high doses
 - Sleep deprivation

- Organic causes likely to precipitate violence
 - Electrolyte imbalance
 - Hypoxia
 - Intoxication
 - Delirium
- Patient characteristics likely to precipitate violence
 - Anxiety
 - Grief
 - Long hospitalization
 - Loss
 - Pain

Clinicians need awareness of the risk of assault when patients exhibit the signs of impending violence listed below. Several of these signs represent the fight or flight response associated with autonomic stimulation. Thus, evidence of tachycardia and other physiological effects of noradrenaline in a patient suggest that violence is impending. Additionally, clinicians must use their intuition that violence is imminent. If clinicians feel apprehensive in a clinical situation, then they ought to follow their instinct and guard their personal safety. Clinicians may feel impervious to danger, but they are not.

- Signs of impending violence
 - Agitation
 - Anger
 - Catatonia
 - Chanting
 - Clenched fists
 - Clenched jaw
 - Cursing
 - Darting eye movements
 - Demanding immediate attention
 - Dilated pupils
 - Excitement
 - Flared nares
 - Flushed face
 - Hostility
 - Impulsivity
 - Loud outbursts
 - Name calling
 - Obscene language
 - Opening and closing the fist
 - Pacing
 - Pointing

- Possession of a weapon
- Profane language
- Pushing furniture
- Restlessness
- Scars
- Slamming objects
- Smell of alcohol on breath
- Staring eyes
- Sudden movements
- Tattoos
- Tension
- Uncooperativeness
- Widened eyes

Clinicians may prevent future violence by patients by recognizing traits of patients who are likely to become violent. Arango and colleagues and Scott and Resnick indicate that past violence is the strongest risk factor for future violence.^[6,4] Characteristics of individuals demonstrated by actuarial studies to be associated with the likelihood of violence include previous history of violence, age younger than 30 years, male sex, current abuse of and dependence on alcohol and/or substances (see Alcoholism and Alcohol and Substance Abuse Evaluation), alcohol intoxication (see Alcoholism), and current psychotic symptoms.^[4] Acting on the hallucinations and delusions of psychosis is particularly associated with violence.

- Characteristics of individuals presenting increased risk of behaviors dangerous to others
 - Acute confusional state (see Delirium)
 - Acute organic psychosis
 - Alcohol abuse and dependence (see Alcoholism)
 - Alcohol intoxication (see Alcoholism)
 - Anger and aggression (see Aggression)
 - Antisocial personality disorder (see Psychiatric Illness Associated With Criminality)
 - Bipolar disorder
 - Borderline personality disorder (see Personality Disorder: Borderline)
 - Delirium
 - Delusional syndromes
 - Dementia
 - Family history of criminal behavior or violence
 - Financial instability
 - Fire setting
 - Grandiosity
 - Head injury
 - High psychopathology scores
 - History of family violence

- History of physical abuse
- History of sexual abuse
- History of violence to self or others
- Homelessness
- Impulsivity
- Learning disability
- Lower income
- Lower socioeconomic class
- Male sex
- Mental disorders
- Mental retardation
- Minority status
- Paranoid psychosis
- Personality disorder with emotional instability
- Personality disorders
- Poor empathy
- Poor insight^[7]
- Poor social networks
- Scars
- Single
- Schizoaffective disorder
- Schizophrenia
- Sex offender
- Special education
- Substance abuse and dependence (see Alcohol and Substance Abuse Evaluation)
- Tattoos
- Torture of animals
- Treatment with more than one class of medication
- Unemployment
- Youth

Additionally, Scott and Resnick report that conduct disorder is common in violent youth.^[4]

Identification on interview and examination of traits suggesting the likelihood of violence ought to alert clinicians of the need for special care in the continued assessment of the individual. These findings include the following:

- Interview and examination findings suggesting a likelihood of violence
 - Access to guns or other lethal weapons
 - Agitation
 - Anger

- Delusions, persecutory
- Disinhibition due to head trauma and other neuropathology
- Intoxication with alcohol and/or other substances
- Participation in gangs and other violent groups
- Poor impulse control
- Reckless actions
- Risk taking
- Verbalization of command by auditory hallucinations to perform violent acts
- Verbalization of intent to kill
- Verbalization of plan to take revenge
- Violence at home

Preparation for Possible Violent Incidents

Preparation for possible violent incidents on emergency and psychiatry wards

Recent tragedies around the world demonstrate the need for preparation for unexpected incidents. Violence awareness training is needed in settings where neurologic patients receive care, particularly emergency and psychiatric wards. Planning for violence is a means to institute strategies to abort the escalation of potentially violent incidents into tragedies. Administrative leaders must plan for the possibility of threats of bombs and other explosive devices, fire, and hostage situations. Alarms and emergency communication, telephones, UHF radio systems, and other emergency communication plans must be implemented to prepare for alarm states. They must be checked regularly to verify that they are operational. Drills must be conducted regularly to make sure that staff can use the emergency communication systems effectively.

Self-defense and confrontation avoidance instruction are appropriate for staff members in contact with neurologic patients, especially on emergency and psychiatry wards. Violence can often be avoided by listening to the complaints of the individual. Staff persons may effectively abort potential aggression by repeating the complaints of the patient empathetically and suggesting that the patient will be helped to find effective nonviolent means to resolve them.

Because most people are right-handed, look in the person's right hand for a weapon. If the person is wearing a coat, look for evidence of a potential weapon on the right side. Courses are available to train individuals in police methods of self-defense (see Help for Heroes).

Interventions to Abort Violence

Identify patients with high risk for violence

In a study by Warnock-Parkes et al, both the Machismo scale and the scale for the Acceptance of Violence on the Maudsley Violence Questionnaire were associated with the likelihood of violence in inpatients.^[8]

Strategies to avoid violence by neurologic patients

- Do not interview or examine patients in the clinician's home.
- Work with the hospital or clinic administrator to survey the scope of potential violence at the institution so that preventive measures can be undertaken.
- Avoid furniture that permits blocking exit from the room.
- Equip all examining rooms, offices, and nursing stations with panic buttons.

Passive measures to monitor patient behavior

Good lighting systems in the facility, outside the walls, and in parking lots and adjacent regions are appropriate to identify persons who may be in a position to assault staff. Closed-circuit television cameras with videotape monitoring can be installed to provide documentation of the presence of persons who may institute violent acts against patients and staff. Security staff may actively monitor the cameras to investigate behaviors that arouse suspicion.

Building design

Clinics and hospitals can be designed to incorporate measures to prevent wall scaling and roof stepping. Measures can be instituted to hinder the concealment of contraband and weapons. Buildings must be constructed with fixtures and fittings that cannot be removed readily for use as weapons. Doors for patient-occupied rooms must be constructed to open outwards. Such a configuration eliminates the means to crush a staff person between the door and the wall. Doors should have firm windows so that the interior can be observed readily. Patient rooms must be designed so that patients cannot block the clinician's exit. Closed-circuit television monitoring, panic buttons in all clinician areas, and 2-way communication systems can help prevent violence toward clinician

Clinician Behavior to Minimize the Risk of Violence

Always keep a patient who is likely to become violent in clear view.

The clinician should never turn his or her back on a potentially violent patient. Make sure that violent patients do not invade the clinician's personal space (eg, 4-6 feet around the staff member).

If physically attacked by a patient, use techniques of self-defense (see Help for Heroes).

Physical restraint

Often, clinicians can calm a potentially violent patient by establishing a therapeutic alliance with the patient. Patients may then learn to talk about their angry feelings instead of acting on them. By requesting additional staff and instituting one-to-one observation of a patient with aggressive impulses, clinicians may be able to establish tranquility. Patients at risk of committing violence may be aided to control their aggression by the presence of a team of health workers, including physicians, nursing staff, social workers, security guards, and staff trained in the administration of physical restraint.

In order to make the experience of being placed in restraints as therapeutic as possible, explain to the patient what is going to

happen and why. For example, tell the patient, "You are going to be placed in restraints now because you are threatening me in a loud voice and moving to hit me. You need to learn to find better ways to express yourself than yelling and hitting. Because you appear unable to control your urge to hit me, you will be placed in restraints for a short time until you can control your impulses to scream and to hit."

Involving the family by informing them that the patient is being placed in restraints may be helpful. Patients must give permission to contact family members. The patient can be told, "I need to let your family know that you are at risk of killing yourself or someone else. Who would you like to be notified? What is the telephone number?"

If the patient does not provide the name and telephone number of a family member, then document that the patient declines the request. If the patient does provide the name and telephone number of a family member, then call the person immediately. A possible conversation is as follows:

"Hello. I am Doctor Smith calling from the hospital to let you know that Mr. Jones had to be tied to his bed because he tried to kill his nurse. We need your help to teach Mr. Jones better ways to control his angry feelings. Please come to the hospital to ask him to cooperate with the staff. I am very worried about Mr. Jones' emotional condition. He is experiencing an extremely urgent psychological crisis. Please help us."

Check the condition of the patient frequently. Assign a nursing staff member to observe the patient on a one-to-one basis for the duration of the restraint. Monitor respirations, heart rate, and blood pressure every 15 minutes. Institute cardiopulmonary resuscitation if the patient experiences cardiac or respiratory arrest. Watch closely to verify that the restraints do not impair circulation. Position the patient comfortably.

In the chart of the patient, document the need for the use of restraint. Explain that other interventions to control the aggression of the patient were unsuccessful. Write orders for restraint for periods of not more than 2 hours. If the patient continues to actively threaten assault after 2 hours of restraint, then write another note to document the continued need for restraints. Inform the patient and family. Write an order for another episode of restraint for up to 2 hours. Administer a parenteral injection of antianxiety or antipsychotic medication, if needed.

Release the patient from restraints as soon as the violent behavior subsides. Keep the patient in restraints no longer than necessary.

When the patient is released from restraints, explain to the patient and the family that restraints had to be applied for fear that the patient would injure him or herself or others. Explain the need to think about possible consequences before yelling or threatening others. Explain the need to learn constructive nonviolent methods to express hostility. Enroll the subject in anger management training programs to learn effective nonviolent means of handling anger. Useful strategies to prevent future episodes of violence include participation in relaxation training, including meditation and yoga. Provide educational videotapes to the patient and the family to train them on how to identify potentially violent situations and how to minimize the risk of assault.

Pharmacological Restraint

The differential diagnosis of disinhibition and aggression is considerable, but the cause in each patient must be clinically determined as accurately and as rapidly as possible because the correct diagnosis facilitates the use of the most appropriate medication in the immediate setting.

Deterioration of a hospitalized patient necessitates the consideration of a broad differential diagnosis.

Common medical problems, including infection, electrolyte imbalances, and intoxication or withdrawal from alcohol, drugs, and other substances, must be ruled out.

A patient may be experiencing insomnia on a noisy ward exacerbated by conversations, radio, and television of nearby patients, visitors, and staff. Adequate lighting helps to facilitate the development of a regular sleep-wake cycle. Bright lights in the morning help to keep hospitalized patients awake. At night, a quiet dark room illuminated by a faint night-light fosters sleep.

Behavioral deterioration may reflect discomfort. If the patient is in pain, then prompt diagnosis and treatment of the cause helps the patient to regain behavioral control and equilibrium. Patients typically experience great relief and satisfaction when adequately treated for constipation and bladder distention.

The trauma of staying in an acute hospital can be alleviated by brief visits by the clinicians. Before the admission, the clinicians can inform the patient and the family what to expect in the hospital. Thus, the patient and family can be prepared for the daily hospital routine occurrences that often frighten patients and families. By asking patients and their families about their concerns regularly in the hospital, the clinicians can provide the support, reassurance, and encouragement to handle the stresses of the procedures and other interventions.

Both depression and mania can result in behavioral deterioration in a hospitalized patient. Agitation resulting from depression or mania often resolves with the administration of antidepressants or mood stabilizers for the target behavioral symptoms.

Explosive behavioral deterioration in a hospitalized patient can often be controlled by behavioral management. The appearance of a team including clinicians, nurses, aides, staff, and security frequently persuades a belligerent patient to cooperate with the recommended activities. Usually, the presence of security convinces an agitated patient to go back to bed or sit in a chair. If parenteral sedation is needed, then 1 or 2 mg of haloperidol IM usually is adequate.

Rarely, restraints may be required for an agitated patient recalcitrant to more conservative interventions.

If efforts to verbally de-escalate a violent situation are unsuccessful (without, and then with, the presence of security personnel), the patient always should first be given the choice of accepting an oral medication, with an explanation of the immediate need and its benefits.

Patients who have been diagnosed with psychotic disorders, including mania, and those experiencing behavioral dyscontrol and disinhibition in the context of mental retardation, dementing processes, personality disorder, or history of traumatic brain injury

(TBI), are often appropriate candidates for antipsychotic medications. Psychosis, such as mania, requires as a standard of care first-line treatment with antipsychotics, and patients with cortical dysgenesis or destruction (as in mental retardation, dementia and trauma) are at greater risk of disinhibition and induction of delirium by use of benzodiazepines. Rocca and colleagues recommend the use of typical and atypical antipsychotics and benzodiazepines to reduce violence in patients with mental illness.^[9]

Haloperidol continues to be the favored neuroleptic if rapid tranquilization is required. In frank psychosis, such as that due to mania, violence or aggression may become manifest. A standard practice is to administer 1-5 mg of haloperidol orally or parenterally to treat the psychosis. Additionally, a standard practice is to administer 25-50 mg of diphenhydramine to sedate the patient by its antihistaminergic effect and to lessen the risk of neuroleptic-induced dyskinesia through its anticholinergic action. Administration of haloperidol may be repeated if no effect is noted within 45-60 minutes, although administer with care so that the maximum recommended dose is not exceeded.

Arango and colleagues report that the use of depot antipsychotics reduces violence in previously violent people with schizophrenia who comply with the treatment.^[6]

Patients with hypofrontal disinhibition, encephalopathy or delirium, or dementia who are in immediate danger of escalating to the point of committing aggressive or violent acts are better treated first with an atypical antipsychotic such as olanzapine or risperidone if they accept oral medication. Use of these medications is justified in this patient population because benzodiazepines are hypothesized to increase disinhibitory potential as well as worsen delirium. In lieu of the atypical antipsychotics, judicious use of low-dose haloperidol, oral or parenteral, usually results in a gently calming effect and sedation. Diphenhydramine is not recommended in this patient population because of its deliriogenic effects. Fortunately, for application to those patients susceptible to dystonia or other movement disorders in context of the use of the typical antipsychotics, parenteral forms of atypical antipsychotics are now being introduced.

Clinicians must avoid overuse of tranquilizers, particularly in the middle of the night. By instituting the measures described in this section, clinicians can often abort catastrophes at night and on weekends.

The TASER is a tool used to restrain individuals by stunning them. The use of a TASER device is not recommended in neurologic settings due to the possible adverse effects on the patient. However, neurologists and other clinicians are likely to encounter patients on whom the TASER has been administered by law enforcement and others. Rhabdomyolysis is one of the complications of administration of TASER instruments. Persons with rhabdomyolysis are likely to be referred to neurologists and other clinicians.^[10]

Debriefing and Counseling After a Violent Episode

Staff members are likely to develop psychological problems after a violent experience with a patient. To minimize the adverse effects of patient violence on staff, activities to promote the mental health of the staff are helpful. Please see Acute Treatment of Disaster Survivors for further information. Adverse effects of violent patient incidents on clinicians include the following:

- Feeling upset

- Blaming self
- Fear of caring for patient in isolation
- Irritability
- Anger
- Headache
- Low worker morale
- Poor job satisfaction
- Poor worker retention
- Insecurity
- Career change
- Lost time from work
- Refusal to identify self to patients

Staff members benefit from debriefing sessions immediately after a violent incidence with a patient. They are encouraged to describe simply and clearly what happened. Obtaining a precise statement of the events is appropriate. The staff person benefits from the belief that others care about the welfare of those involved.

Victims of violent episodes are at risk of developing posttraumatic stress disorder. Psychological interventions may be helpful to abort development of severe psychopathology.

Proactive Administrative Procedures to Handle Violence

Underreporting of incidents of violence carried out by patients toward staff is common. Staff may fear being blamed for episodes of violent patient behavior. Reporting takes time that staff may be reluctant to give. Staff may feel that reporting is not important. Therefore, the administration must implement a policy of full reporting without punishment of the staff that report violent incidents. Such reporting not only allows proper management of the immediate incident but also assists in research on the epidemiology of such incidents and their management and eventual prevention.

To objectively analyze the problem of violence, all incidents must be reported in a uniform manner. All staff should be required to report all episodes of possible aggression without fear of retaliation. Staff members often express reluctance to come forth with evidence of patient assault for fear of being blamed for the episode. Administrators must clearly and unambiguously inform staff that reporting possible violence will not be held against the worker. Pertinent information about the episode (ie, who, what, where, when, how) must be recorded for review.

In order to provide an objective assessment, the information ought to be reviewed by administrators who are not involved directly. Further information and consultation should be sought from as many individuals as necessary to fully comprehend the incident. Please see *Acute Treatment of Disaster Survivors* for further information.

Not only must the worker involved in the assault provide details about the situation, but his or her physical and psychological needs also must be met. Workers must feel that someone cares about them. The assault victim may find simply reporting the facts to a nonjudgmental colleague to be therapeutic. Venting emotions after the incident may also be helpful. Any physical

injuries sustained by the assaulted clinician must be identified and treated. Furthermore, the psychological effects of assault by a patient must be addressed. Short-term intensive psychotherapy may facilitate the psychological recovery of the assaulted clinician. Other assault victims may develop serious mental disorders, such as depression, requiring pharmacotherapy or even psychiatric hospitalization.

Situations that lead to risk of clinician assault need to be corrected when identified.

Future Directions

Particular biological markers of violence may be screened in settings with high risk of violence, including emergency and psychiatry wards.

The association of the dopamine receptor D2 Taq A1 allele with impulsive aggressive violent behavior suggests that screening for this allele may help identify patients who are more likely to be violent. In the future, batteries of screening procedures may be available to identify patients at greater risk for violence. Clinicians could then approach these patients with appropriate caution.

Legal aspects of clinician assault vary widely based on location. The screening of DNA of all patients at a facility after a violent incident may identify the perpetrator.^[11] However, mandatory genetic testing of a class of patients may challenge ethical and legal standards. Clinicians are wise to learn the local laws. Future research to compare and contrast the legal aspects of patient assault is warranted.

The principles of the use of seclusion and physical restraint also vary by location. Awareness of local practices is important. Research to determine optimal practices in the application of seclusion and restraint is needed.

Clinical aspects of safety with special neurologic patient populations, including pregnant women, children, and prisoners, warrant particular review.

For further information on clinical safety, please refer to the following sites on the World Wide Web:

- Zero Tolerance for NHS Violence (BBC News)
- The Faculty and Staff Assistance Program at Johns Hopkins
- Help for Heroes

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Keywords

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